		Sta	te of Maryland				-		_	
	٠	For State Registrar	,			of Death		Reg. I		28001
Physicia	ın	Decedent's Name (First, Middle, Last)	1100	0:-			2. Date of Month	Death	Day Year	3. Time of Death
/Medic		PHYLLIS E		R45				8	24 09	
Examine	er	4a. Facility Name (If not institution, give street a	e ROAD		4b. City, Tow	m, or Location o	River		4c. County of Deat	more
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ist birthday)	If Under 1 Ye	ear If Under	24 Hrs. 8. Date of	Birth		nplace (State or Foreign untry)
Director		220-80-2925 10M 2	7	Yrs.	Months Da	ays Hours		Day, Yea	27 Co	England
and **		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Lo	ocation					10d. Inside City Limits
Maryle f sho	ō	MD Belt. C		altr						1 ☐ Yes 2 X No
the 728e-	Director	10e. Street and Number	0 13	allir	10f. Zip Coo	de		10g. (	Citizen of What Co	untry?
th with	a D	6910 Circle	Rd			2122	0	1	ngland	
r deal	Funeral	Ап	is Decedent Ever in U.S ned Forces?	13.	Was Decedent	of Hispanic Orig	gin? (Specify Yes or , Puerto Rican, etc.	No-	14. Race - Ame Black, White	rican Indian,
36 s afte	by Fu	If Y	Yes 25 No es, Give ar or Dates:		1□ Yes				Specify:	shite.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene. ther then "natural", or Items 23a or 28e-f show ant, the Medical Exarté serminat les medified at ant, the Medical Exarté serminat les medified at	ted t	15. Decedent's Education	1	16a. Dece	dent's Usual Oc	cupation		16b.	Kind of Business/	Industry
215 thin 7:	ble	(Specify only highest grade comp	llege (1-4or 5+)			ccupation one during most atired)	of working			
21 sed will ygien therefore the transfer the	Completed	10th		HOM	emaker 				own hon	ne 
and Ibe fill Intal H ed oth	Be	17. Father's Name (First, Middle, Last)  John Barber					r's Name <i>(First, Mic</i> cah Bowd		en Sumame)	
Maryland 212 nd 2 should be filed with lith and Mental Hygiene 27 is marked other tha r traumatic event, than	ပ	19a. Informant's Name/Relationship (Type, Pri	nt)	19b. Mailir	ng Address (Str		or or Rural Route Nu		v or Town State 7	(in Code)
Ma ind 2: alth ar 27 is		James P. Harris					Vay Abin			,,
Ore, esta of He of He of He of He		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Remova	20b. Pla	ace of Dispo metery, crei	sition (Name o	f place)	Date		Location - City or	
lime Pagiment ment: Hant: Hant: H		'4 □Donation 5 □Other (Specify)	Bay	view	natory or other Cremat	cory		Ва	ltimore	e MD
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event. The Medical Exame arrival be notified at once.		21. Signature of Funeral Service Licenses	mulle	22		Mace A	Connel	_		meofEssex
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death;	Do not ent					AC PID 2	Approximate Interval Between
Prysician		Immediate Cause (Final disease or condition	natural	C un						Onset and Death
/Medical Examiner		resulting in death)	oue to (or as a conseque							
	<u>_</u>	Sequentially list conditions, b.	Oue to (or as a conseque	ence of:						
uted uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	,	,						
3760, ate be executed hysician and he burial-transit	Exa		Due to (or as a conseque	ance of):						
8760, ate be ex hysician a	lcal	d								
Records, P.O. Box 68 The law requires that the death certificat the has been signed by the attending phy oage 2 should be detached for use as the	by Physician/Med	IF FEMALE:	es, outcome of pregnan	O1						
Box eath cert	clan	in the past 12 months?	es, outcome of pregnam Live birth 2 ☐ Fetal of Pregnant at time of dea	death 3	Ectopic pregna Other (specify			1	23d. Date of deli Month	very Day Year
by the drached	hysi		Unknown					_		
S, P	by P	Part II. Other significant conditions contributing	ng to death but not result	ting in the u	nderlying cause	given in Part I.	23e. D	id tobacco	o use contribute to	the cause of death?
Cord		hypertens?	M				1	Yes	2 □ No 3 Pro	bably 4 Unknown
of Vital Records, Physician: The law requires to this certificate has been signed rall director, page 2 should be considered.	Completed	tobacco a	buse				24a. V	utopsv	prior to d	topsy findings available ompletion of cause of
Vital Fician: The certificate							1 □ Ye			2 No
f Vit ysicial ysicial is certif	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 No Hospital	: 1 ☐ Inpatient 2 ☐ E	D/Outrotion	t 3 DOA	Othor	of Death Check or rsing Home 5 2 H		a □011	
on of olding Phys	-	27. Manner of eath 28a.		28b. Time of	I 3 DOW	njury at Work?			jury occurred	nry)
SiOr or Aff	atio	2 Accident investigation	(WOMM, Day Year)	injury		1 Yes 2 N	40			
Division of Vital or Attanding Physician: after death Director After this certification the funeral director.	ij	3 Suicide 6 Could not be determined 28e.	Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, offi	ice		n (Street : Town, Sta	and Number or Ru ate)	ral Route Number,
Hospital Pours a Funeral C tely filled	ဦ	29a. Certifier Sertifying Physician:	To the best of my knowl	ladge doubt	a conversed at the	a time data and	t class and due to		(-) d m	
Division  To the Hospital or Attend within 24 hours after dealh To the Funeral Director A completely filled in by the fu	Medical Certification:	(Check only 2 Medical Examiner: Or	the basis of examination the basis of examination displayed manner stated.	on and/or inv	estigation, in n	ny opinion, deat	h occurred at the tin	ne, date a	nd place, and due	to the cause(s)
To the within 2 To the complet	ž	29b. Signature and title of certifier			29c. Lic	ense number		29d. D	ate signed (Month	, Day, Year)
Λ		Saw	O MU)		D	1590	4	8	.24-0	5
1		30. Name and address of person who complete	d cause of death (Item 2			1 D	100	1		71271
Stat	0	31. Date filed (Month, Day, Year)	32. Registrar's Signatu			lair R	a sal	XIN	ETR MY	4256
Registra	~		)	6 do	arde)					
		6. 20 (1)	in the said of the said	10						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 9:13 **Physician** Helen Susan Jenkins 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

The state of Birth (Month, Day, Year)

The state of Birth (Month, Day, Year)

The state of Birth (Month, Day, Year) Birthplace (State or Foreign Country) (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2804 218-18-0356 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10b County 10c. City, Town or Location item 27 is marked other then "naturel", or Items 23a or 28e-1 show other traumatic event, the Medical Enaminar must be notified at 1 Yes 25No Maryland Baltimore Essex **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with U.S.A. 308 Nicholson Road 21221 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or tlen any injury or other traumatic event. 1 ☐ Yes **2(X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🎗 🔯 No Specify: ģ ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosalie Sidor John Rutkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8703 "C" Fowler Avenue, Baltimore, Maryland 21234 Daniel Jenkins (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXurial 2 ☐ Cremation 3 ☐ Removal from State Aug. 27, 2005 Baltimore, Maryland Saint Stanislaus A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Bruzdziński Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Libenses 23a. Part1. In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final diseas or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) attending physician P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🕅 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide determined 4 T Homicide To the Hospitel within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 9000 TON TILBURT FRANKLIN SQUARE DRIVE BALTIMORE 31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiena 28003 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:10 PM August 24, 2005 Kenneth G. Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Chesapeake Hospice House Linthicum Anne Arundel 8. Date of Birth (Month, Day, Year) APR 23,1931 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Yrs. 021-64-7548 74 Wales **Director** Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral, or iteme 23a or 28e-f show Examiner must be notified at 1 Yes 2 No Directo Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 USA 2114 Chesapeake Harbour Drive, #102 filed within 72 hours after death Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo White Specify Specify: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Madical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) German Wallcovering & Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Fabric Manufacturing 4 President 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Int; If item 27 Is marked o Cyril Jones Winifred Hopson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403 19a. Informant's Name/Relationship (Type, Print) Pauline V. Jones/Wife 2114 Chesapeake Harbour Drive, #102, Annapolis, MD 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o Metro Crematory, Inc. 8/25/05 1 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Ocensee 22. Name and Address of Facility Cremation Society of MD, Inc. liv Edward A Cregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hepax Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 🖫 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Vother (Specify) Hospice Certification: To this neral Director: After the 27. Manger of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number 1) August 24, 2005 30. Name and address of person who of death (Item 23a) (Type, Pript) NSE HGHWAY ANNAPOUS MOZIFUI MICHMER 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 2 6 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Ruth A. Jackson 08/ 22/ 11:00pm2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 1423 Andre Street Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/3/1925 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 1 □ M 2 😾 F 79 220-18-3683 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show 7 is marked othar than "natural", or items 23a or 28a-1 show traumatic avant, the McCleal Examinar must be notified at Yes 2 No Baltimore City N/A MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 USA 1423 Andre Street Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏Yes 2. 2. 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ğ 3 Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 hand Mental Hygiene. 7 is marked othar than "I College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 9 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fredericka Jones Joseph Novak 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, ... 1452 Andre Street, Baltimore MD 21230 19a. Informant's Name/Relationship (Type, Print)
Bonnie L. Werner / Daughter Pages 1 and 2 s nent of Health an of Health itam 27 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 08/27/2005 = 5 Baltimore Maryland permit. Page Department of Important: If any injury of 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. Victor P. Doda, Jr. 1501 E. Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the burial of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ned by the a 9☐ Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2**X** No 2□ No 26. Place of Death (Check only one) completely filled in by the funeral director, Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 □Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural or Attanding 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 901 E. Fort Balto Md 2. Registrar's Signature Alan Jennis 31. Date filed (Month, Day, Year) 32 State Registrar AUG 2 6 2005

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend item 18 per in 8846 8-26-05 Vt. State of Maryland / Department of Health and Mental Hygiene 0 0 5

28005 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST 25 Dav AM Physician R 2005 1:45 **JACOBSON** ANNF /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner APT. BALTIMORE 3407 GLEN AVENUE If Under 1 Year tf Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/07/1909 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗶 F MD 96 214-40-5099 Director Usuat Residence of Decedent 10d. tnside City Limits 10c. City, Town or Location 10a State 10b County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 □ No BALTIMORE MD N/A Direct 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21215 U.S.A. 3407 GLEN AVENUE APT. C Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION **TEACHER** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or othar traumatic event once. Be SCHAPIRO Shapiro **JACOBSON** IDA MAX 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3305 BANCROFT ROAD - BALTIMORE, MD 21215 ALAN ABRAMOWITZ / COUSIN 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition TTZ NUSACH ER TAMID) 1 N Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 08/25/2005 ROSEDALE, MD 21. Signatur ral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. shock Immediate Cause (Final disease or condition Frrysician estr /Medical resulting in death) Due to (or as a cons plence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit on things attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 XNo page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No Certification: To his 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08-25-2005 1)-20157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 0 21215 31. Date filed (Month, Day, Year) AUG 2 6 2005 32. Registrar's Signatu State Registrar

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 28007 For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 5:50 P M **Physician** Kurlis, Sr. August Robert E. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore 4122 Glen Park Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 18, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 80 Maryland Yrs. 215-14-7967 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt: If item 27 is marked other then "naturel; or Items 23a or 28a-f ehow 10c. City, Town or Location 10b. County 10a State other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Baltimore Director Maryland Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21236 4122 Glen Park Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WW II 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Construction welder 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Marie Didwald Kurlis Joseph ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4122 Glen Park Road, Baltimore, MD 21236 Mrs. Ruth Kurlis (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition perrat. Pages 1 Department of h Importent: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Parkville, Maryland 8/27/2005 Parkwood Cemetery \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of uneral service License 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final months Physician lianan disease or condition resulting in death) /Medical Due to (or as a lonsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9☐ Unknown the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? /es 25 No 1 ☐ Yes Hospital or Attending Physicien: 24 hours after death. Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 📆 No 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within ? To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) OVK 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 200 c per in 6847 Department of Health and Mental Hygiene For Amend Item 20b-c per fh G847 9-8-05 tas Registrar Amend Item 20b-c per fh G847 Certificate of Death 9-20-05 tas Reg. N2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** KWARTENG MARGARET AUGUST 14 2005 2:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING
If Under 1 Year If Under 24 Hrs. 8. Dat
Months Days Hours Min. (Mc MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1956 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2X F Months Yrs. 48 Director 218-06-6651 OCTOBER Ghana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 271s markad other than "natural", or Itams 22 natural. 10a, State 10c. City, Town or Location 10b. County 10d, Inside City Limits 1 Yes 2 No Director Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20720 8507 Bates Drive U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs Bill Speçalist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kyei Foster Boateng 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8507 Bates Drive Bowie Maryland 20720 Charles Kwarteng/Husband 20b. Place of Disposition (Name of 20a. Method of Disposition 9 10<sup>□</sup>85 300 Location - City or Town. Garneter Fernatory of other place) 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Plot

22. Name and Address of Facility Agogo, Ghana Family -05 21. Signature of Funeral Service Ligensee J. B. Jenkins Funeral Home -. D. 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faillife. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Cause (Disease or injurthat initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by i should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page this certificate 1 ☐ Yes 1 ☐ Yes 2 ☑ No 2X No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To funeral 27 Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: completely filled in by the 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physic art. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29b. Signature and title di certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sonja C. Wyche  $\mathcal{Q}$ . M 1500 Forest Glen Road Silver Spring, Maryland 20910

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 6 2005

			1 - State Registrar	State of Maryland	/ Department Certificate	of Health and of Death	Mental Hyg	ienę	005	28009
			1. Decedent's Name (First, Middle, Last	)			2. Date of Dea Month	h Day	Year	3. Time of Death
	Physicia /Medic		Harding Theodor	e Keene			Aug. 21	, 20	05	2:15 M
	Examin	er	4a. Facility Name (If not institution, give			own, or Location of Deat	th	4c. C	ounty of Death	
			1614 Forest Park  5. Social Security Number 6. Se			timore Year   If Under 24 Hrs			n/a 9. Birtho	place (State or Foreign
	Funeral Director	[		2m 2□ F 81	Yrs. Months [	Days Hours Min.	Mov 27	Year)	Cour	ntry)
	D		Usual Residence of Decedent				110/10/2/3			
	arylar show	<u>-</u>	10a. State 10b. County		Town or Location					0d. Inside City Limits  1
	the M	ectc	MD n/a  10e, Street and Number	Ba1	timore 10f. Zip C	ode		On. Citize	en of What Cour	
	with Ba or	Dir	1614 Forest Park A	WQ.	212				USA	,
	death ms 2%	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. Was Deceder	nt of Hispanic Origin? (S / Cuban, Mexican, Puer	Specify Yes or No-		4. Race - Americ Black, White,	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Exatination Little Lading ange.		1 Never Married 2 Married	1 Tyes 2□No1941 If Yes, Give	1 ☐ Yes 2√	7	nite	5		nite
21215-0036	hours tural',	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates: 1946	16a. Decedent's Usual	WI	1100	16b Kin	d of Business/In	
15	in 72 n" n	plete	(Specify only highest grad	le completed)	(Give kind of work life. DO NOT use	done during most of wo	orking	TOD. IXIII	a or basinessin	dustry
212	d with giene. or tha	mo	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Mechanic			Otis	Elevat	or
pu	al Hy d othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden S	Sumame)	
yla	ould to Ment Marked	P	John W. Keene			Mattie F				
Maryland	d 2 sh h and 7 is rr traum		19a. Informant's Name/Relationship (T) Theresa Keene - D		19b. Mailing Address (S 4115 Baker I			-		(Code)
ē,	1 and Healt tem 2		20a. Method of Disposition	20b. Pla	ice of Disposition (Name	of	Date		ation - City or To	own, State
Baltimore,	bages ant of ht: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ L	Removal from State	metery, crematory or other don Park Cen	- 1	25 05	Ra1+	imore C	tu
alti	mit. F partm portar / injur		21. Sign July of Funeral Service Livens			Address of Facility Lo				
Ö	permii Depar Impor any ir once.	9 9	KUM LC	Manger		lkens Ave.			aryland	21229
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. one cause on each line.	Do not enter the mode	of dying, such as cardia	ic or respiratory arr	est,		Approximate Interval Between Onset and Death
	Priysician	id I	Immediate Cause (Final disease or condition	a lur	ng cancel					months
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
4	130	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):					
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С						
oʻ	e exection and an arrial-tr	Exa	resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	cate be executed physician and the burial-transit	dicai		d						
9		/Me	IF FEMALE:	23c. If yes, outcome of pregnan	cv			11 25	3d. Date of delive	20/
Вох	death certif e attending id for use as	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of de	death 3 □Ectopic preg			2.	Month Month	Day Year
0		Physician/Me	9 Unknown	9□ Unknown						
o.	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but not resul	ting in the underlying cau	ise given in Part I.				he cause of death?
Records,	w require been sig should b						1 🗆 Y	es 2 🗆	No 3 ☐ Prot	pably 4 Munknown
ecc	e law r has be je 2 sh	ompleted					24a. Was a autop:	SV	prior to co	psy findings available mpletion of cause of
E H	Th ate pag	Con						2 No	death?	21 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.00	ath (Check only or	-	T0:: (0 ::	_
of	Phys r this sral di	To :	1 Yes 2 No 27. Manner of Death	1 L Inpatient 2 L E	R/Outpatient 3☐ DOA 28b. Time of 28c	. Injury at Work?	Home 5 Resid			y)
ion	Attending or death. ector: After by the fune	atior	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
Division of Vital	Attendier death.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory,	office	28f. Location (S City or Tow		Number or Rura	al Route Number,
ō	Hospital or A									
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical		/sician: To the best of my know iner: On the basis of examinati and manner stated.						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	29c.	License number	2	9d. Date	signed (Month,	Day, Year)
)	- × + o		1 5 TAM MA			D24170		Au	iuit 23	2005
1.	V		30. Name and address of person who d	completed cause of death (Item			ove, Mī	, .50	just 23, 201	D+0/-
V			ETSOMD Richer		N Entaw S	it Bultim	iorz, MT	21	201	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure					
		001	AUG 2 6	LUUJ REMINES	M. Sperke					

DHMH 17 Rev 1/2001

KEENE augal alspr

HARCHUG T.

				State of Maryland / Department of State Registrar  State of Maryland / Department of Certificate (		Лental Hygi	ene 2005	28010
		Physicia	s an	1. Decedent's Name (First, Middle, Last)  VERRY FOWARD LAWSON		2. Date of Death	Day DAY	3. Time of Death
		/Medic Examin	al	9-	wn, or Location of Death	ving	4c. County of Death	
	-		*	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y	timore Tear If Under 24 Hrs.	8. Date of Birth	N A	nplace (State or Foreign
		Funeral Director		219.60.6549 18M 2 F 53 Yrs. Months D	ays Hours Min.	8. Date of Birth (Month, Day,	(95) Con	nplace (State or Foreign untry) VA
		/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
		ith the Marylar or 28a-f show is notilised at	Director	MD NA BALTIMORE		1/	og. Citizen of What Co	1 KLYes 2 No
		death with the Maryland time 23a or 28a-f show		L BENKERT AVENUE 10f. Zip Co	1229		USA	unity?
		er death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent If Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
	036	72 hours after death with the Maryla "natural", or iteme 23a or 28a-f shov olical Examiner must be notilled at	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes, Give Year or Dates:	No Specify:		Specify: BL	ACK
	15-0	in 72 ho "natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work of life. DO NOT user	Occupation done during most of work retired)	king	16b. Kind of Business/	Industry
	212	ygiene.	Com	Elementary/Secondary (0-12)  12 TH GRADE  College (1-4or 5+)  SUPERVISO				PRATION
	and	d be fill ental Hy ced oth c even	To Be	17. Father's Name (First, Middle, Last)  ALPHONSO LAWSON		ne (First, Middle, M AUSTIN	Malden Sumame)	
	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any injury or other traumatic event, the Modical Examine anginge.	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (S				Tip Code)
		Health tem 27 other tr		20a. Method of Disposition  20a. Method of Disposition  20b. Place of Disposition (Name cemetery, crematory or othe			21229 20c. Location - City or	Town, State
	Baltimore,	Pages ment of ant: if i ury or		4 Donation 5 Other (Specify)  ARBUTUS	08.2		BALTIMORE	MD
	Balt	permit. Departi Import. any inj		21. Signature of Funeral Service Licensee  VAUGHN  5151 BAU	Address of Facility C. GREENE D. NATU PIKE	FUNERAL E BALTO	SERVICE MD 2122	9
•		Physician /Medical Examiner pup up	Examiner	23a. Pan1. Enfer the disease, or complications that caused the death. Do not enter the mode of shock, or haad failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.		c or respiratory arre	est,	Approximate Interval Between Onset and Death Have & Years
RRY	P.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical Exa	Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   0   Unknown   Unknown			23d. Date of del Month	ivery Day Year
16,		ss that t gned by se detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.		bacco use contribute to	<b>&gt;</b> -/
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Division of Vital Records,	sician: The law require s certificate has been si lirector, page 2 should t	Completed			24a. Was a autops perforr	ned? prior to death?	utopsy findings available completion of cause of
10	/ital	ician: 'estifica	Be	25. Was case referred to medical examiner?  Hospital:	Othor	ath (Check only on	ne)	
AWSOR	of	g Physer this eral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Waster Cary 28c. Time of 28c.	4 Nursing H b. Injury at Work?		ence 6 □Other (Spe ow injury occurred	cify)
LAV	ivision	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, or building, etc. (Specify)	1 ☐ Yes 2 ☐ No	28f. Location (St City or Town	treet and Number or Ri n, State)	ural Route Number,
		Hospitai 24 hours a e Funerai l letely filled	edicai Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
		To th within To th comp	Me	29b. Signature and title of certifier  29c. I	D61007		9d. Date signed (Mont August 24	h, Day, Year) 2005
		6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Khandagle MD St. Agnes (tospital 900)	Caton Ave B	altimore, A	Maryland 212	29
		St. Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 2 6 2005				

Jean P. Lee 05-5705 AKG

> with the Maryland Wode

Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: if item 27 ie marked other than "naturai", or itams 23.

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

To the Hospital or Attending Physicien:

deeth.

his

Director:

within 24 hours efter To the Funerel Direct

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 2801 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 23, August 2005 3:44 P Ρ. Lee Jean /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3732 Crestfield Court Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Yrs. 218-44-8474 61 Director 03/01/1944 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f ehor the Medical Examiner must be notified at 11 Yes 2 □ No **Funeral Director** Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3732 Crestfield Court 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical 12 Office Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) IINKNOWN Florence Thomas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Charles Lee / Son 1611 E. 32nd. Street, Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If ite eny injury or ot once. 1 ☐ Burial 2 ☆Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/26/2005 Baltimore, Maryland 22. Name and Address of Facility he Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore. Nd. 21215 21. Signature of Funeral Service Licenses annelle Baltimore, Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at Scene ၉ TXXYes 2 No After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1XX Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, O.C.M.E. August 24, 2005 Hamale 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Southall famela E. 31. Date filed (Month, Day, Year) AUG 2 6

strar's Signature

. MD

111 Penn Street, Baltimore, Maryland

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 28012 005 For State Registrar 2 Date of Death 1. Decedent's Name (First, Middle, Last) 1,236M **Physician** Raymond Lewis Leroy 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Roseda Center Franklin Square Hospital 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (Month, Day, Year)
June 28, 1934 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Maryland 1**X** M 2□ F 71 219-28-2719 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28e-f show other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Nottingham Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 8903 Yvonne Avenue U.S.A. 21236 Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 Never Married 2 Married ö 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Coflege (1-4or 5+) Elementary/Secondary (0-12) Gas & Electric Co. Construction Designer 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Charles Lewis Catherine Zonn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health a Importent: If Item 27 Is any injury or other treasonce. 8903 Yvonne Avenue, Nottingham, MD 21236 Mrs. Jean Lewis (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 8/29/2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 esceri 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiae Arrist disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dire to (or as a consequence of) Examiner ·V anding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 🗆 No 1 🗌 Yes 1 Yes certificate 2 No the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Hospitaf: 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by efter 4 Homicide 24 hours e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hichael Pokin 1000 Franklin x 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Lewis, Kaymond

Please Type or Print in Black Indelible Ink. Ensure All Copies Are I amend item/5, per FH, C846, 8/26/05 TT Amend item 17 per Th 2847 State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0835AM MCKEIVA MULLEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HAVEN NURSING HOME CATONSVILLE 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) If Under 1 Year If 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🛣 F 216.28 88 Director 07.31.1917 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE CATONSVILLE 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 5912 LEEWOOD AVENUE 21228 Items 23a Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: if Item 27 Ie marked other that any injury or other traumatic event, Italians ones. 9 TH GRADE DOMESTIC HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. FIWARDe (First, Middle, Last) -ROBERTS EVERET ESTELLE BALLARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5912 LEEWOOD AVE , CATONSVILLE SR (HUSBAND) JOHN MULLEN, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8-30-05BALTO. MD \* 4 ☐ Donation 5 ☐ Other (Specify) LOUDEN PARK 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signal re of Funeral Service Licensee an 5151 BALTO. NATI PIKE, BALTO. MO 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician END STAGE DEMENTIA MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ĺ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Hospital or Attending 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 94, 2005 alu, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTIMONEMO 21028 10166 7220 PARIL HEAGITS MINUE Usbirah 32, Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28014 Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST Vear **Physician** MARTIN DUANITA 9:40 A 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bultimare If Under 24 Hrs. HOPKINS Hospita NA INEJOHNY 8. Date of Birth (Month, Day 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 1□ M 2 1 F 24 · 30 · 7399 Usual Residence of Decedent MD 12.09.1932 Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other then "neturel", or items 23s or 28e-1 show other treumstic event, the Medical Exp. in an intentition at 1 ☐ Yes 2 ☑ No BALTIMORE Director MD GWYNN OAK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5610 HADDON AVENUE USA 21207 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene Important: If item 27 is marked other then "neturel; or items 23a any injury or other treumatic event, the Medical Exp. there inspects once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 K No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DUTY GED NURSE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) BUILER MELVIN ELEANOR HANDY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (DAUGHIER) 3701 LIBERTY HGTS. AVE BALTO. MD co of Disposition (Name of 20c. Locat TIA MARTIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State ARBUTUS 08.26.05 BALTIMORE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licen an 5151 BALTO, NATL PIKE BALTO, MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOXIC RESPIRATORY FAILURE 48 HOURS **Physician** disease or condition resulting in death) /Medical Examiner MULTILOBAR PNEUMONIA I WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐ Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HUMAN IMMUNODEFICIENCY VIRUS 1 Yes 2 No 3 Probably 4 Ninknown HIP FLACTURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No 1 Yes 2 No of or Attending Physicien: after death. Director: After this certifications 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Thomicide To the Hospitel o within 24 hours aft To the Funerel Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title q 29c. License number certifier MD AUGUST RES 000 2005 s of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOLFE STREET, BALTIMORE MARYLAND 21287 MHANCHA AMA 31. Date filed (Month Day, Year) 8 2005 32 Degistrar's Signature State Solver . Registrar

			For State Registrar	State of Marylan	d / Depa <i>Cer</i>	irtment of H tificate of I	lealth and M D <i>eath</i>	lental Hygien	2005	28015
		·	Decedent's Name (First, Middle, Las					2. Date of Death		3. Time of Death
	Physicia /Medic		IVORY		Mo	SORE		AUGUST 1	9 2005	4:25 AM
	Examin	100	4a. Facility Name (If not institution, give	street and number)	11	0	Location of Death	J 4	c. County of Death	1
i.	- A .	*		OTREEN NURSIN		If Under 1 Year	If Under 24 Hrs.	O. D. A. of Sint	NA	(0)
	Funeral Director		5. Social Security Number 6.36	7. Age (In yrs.)	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Year March 4, 19	r) 9. Birth	nplace (State or Foreign
			Usual Residence of Decedent					marcr) T, I	710	710
	inylan show	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation		0		10d. Inside City Limits
	se Ma	cto	MARYLAND A	IA		BALT	IHORE	C171/		1 XYes 2 □ No
	with the	Dir	10e. Street and Number	· Bass Aus	. Learn	10f. Zip Code	21212	Aog. C		
	eath rules	eral	11. Marital Status	L ROSE AVE.			7 / 0	ecify Yes or No-	4 S A	
2	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23e or 28e-f show event, the Medical Exertifier must be indiffied at	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗖 No	1		ispanic Origin? (Spe in, Mexican, Puerto	Rican, etc.)	Black, White	
Š	ral', c	t by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		∏Yes 2. No	Specify:		Specify: BL	ACK
ק	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	lent's Usual Occupa	during most of worki	ng 16b.	Kind of Business/l	ndustry
V	within ane. than	du	Elementary/Secondary (0-12)	College (1-4or 5+)	IITO. L	LABO 1		57	TATE SEE	CE BUILDING
א כ	filed Hygir other ent,		17. Father's Name (First, Middle, Last)		<u></u>	L/4001		(First, Middle, Maide		CE DUIZDING
Ö	should be ad Mental marked c matic eve	To Be	IVORY	MC	ORE		AGNE	=.5	ROUND	TREE
ary	should and Men s marke umatic	-	19a. Informant's Nam , Relationship (7		19b. Mailin	g Address (Street a	and Number or Rura	I Route Number, City	or Town, State, Z	ip Code)
Ž	s 1 and 2 should f Health and Men item 27 is marke other traumatic		DAWN MOORE	(NIECE)	153	7 MOUN	VTMOR	CIT, BALI	O.MD.	2/2/7 Town, State
o Le	ges 1 it of He if iter or oth		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □	Removal from State	emetery, cren	natory or other plac	(e)			
	tment tant:		4 □Donation 5 □ Other (Specify	) KI	NG ME	M. PAR	K 08-2	5-05 W	OODLAW	DN, MD.
	permit. Pages Department of Important: If i any injury or once.		21. Signalure of Fune all Service LCoo		22 To	. Name and Addres	Ss of Facility 214	Eurom I H	ma Ba	Himore MD.
			23a. Part1. Enter the disease, or comp	olications that caused the death					1110 (301)	Approximate
			shock, or heart failure. List only in Immediate Cause (Final	one cause on each line.		,				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq		INCES				Unknown
	Examiner			. Consestiv	,	crt Fai	luck			Unknown
N.	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
0/00,	icate be executed physician and s the burial-transit	al E	I.	Due to (or as a conseq	uerice oi).					
100		edical		d						
×	death certifica e attending ph id for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		- ·			23d. Date of deli	very
Ď.	0 9 6	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
D	law requires that the de as been signed by the a 2 should be detached	hys	9 Unknown							
ń	es the	by §	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.		o use contribute to 2 □ No 3 □ Pro	the cause of death?
cords	requii	Completed							1	
ည်	2 2 2	nple						24a. Was an autopsy performed?	prior to d	topsy findings available completion of cause of
<u>-</u>	n: The ficate har, r, page		05.11					1  Yes 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		2□ No
VII	Physician: The law r this certificate has t ral director, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpation	t 3 DOA Othe	or	me 5 Residence	6 DOthor (Space	116.1
5	Phy rald	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun Worl		28d. Describe how inj		my)
VISION	or Attending ifter death. Director: Afte in by the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 □No			
<u> </u>	r Attender deat	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Street a City or Town, Sta		ral Route Number,
2	urs aft ral Di									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medicel Exem	ysicien: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the ting restigation, in my of	ne, date and place. pinion, death occurr	and due to the cause( ed at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	and mariner stated.		29c. License	e number	29d. D	ate signed (Month	n, Day, Year)
	/		1 27	2//		Doc	59056	.5	24/05	-
	10		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,				1-11-2	
	\		Daljeet Salu	32. Register of Signal	600	west M	M Royal	Ane "	B=14 1	40 21217
	Sta		31. Date filed (Month, Day, Year)	32. Registrat's Signa	iture //	Soule				
	Registr	ar	MIG 2	ZUUD PARALIFE	J 1960			_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 28016 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** 24 11:43 p M August MALAT BEVERLY GAIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth NOV • 27, 1943 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1□M 21 F Maryland 61 214-40-9387 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State C shows and Mental Hygiene. Is marked other then "naturel", or items 23s or 28s-f show is marked other then "naturel", or items 23s or 28s-f show in marked other the Newtoni Examples or must be notified at 1 ☐ Yes 2 No Pasadena Directo Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21122 315 Hickory Point Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 I No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mikasa Assistant Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Importent: If item 27 Is marked oth
any lijury or other traumetic event
any lig. Be Patricia Pininski Hoy1e Harold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 315 Hickory Point Road, Pasadena, Maryland 21122 Richard H. Malat (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08-29-05 Bayview Crematory Baltimore, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licens Home P.A ena, Maryland 21122 McCully-Polyniak Funeral Hom 3204 Mountain Road, Pasadena, 233 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final Hoda Kin's 400 Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause E. S. U. Jorying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 V 0 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Lath 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Fo the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar Jeanine Werner, 900 Best gate Roca#300, Annayolis, MD

Cenere Wein

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DS 2830

LYDIA R. MAGHARI 05-04062 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a 27, perMF C8/46 8:29-05 TT Unpend item#23a 27, perMF C8/46 8:29-05 TT

2801/ Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) .TMNE 14, 2005 **Physician** 9:00A. Lydia Romero Maghari /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES CAMP SPRINGS 5215 MORRIS AVE If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1 □ M 2 🖾 F Yrs. Philippines None Oct. 18, 1944 Director Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28e-1 ehow r then "naturel", or items 23a or 28e-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2X No Maryland Prince George's Director Camp Springs 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5215 Morris Avenue, #107 20746 Philippines 23a death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status Unknown 1 Yes 24 If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Asian Baltimore, Maryland 21215-0036 "naturel', or þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A Hygiene. Housekeeper Damestic Unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other treumatic event 2002. Be Telesforo Maghari Salvacion Romero ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27C Kalay an Avenue, Cembo, Makati City, Phillipings e of Disposition (Name of Date 20c. Location - City or Town, Evelyn Sampang/Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 2, 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 2005 Metropolitan Crematory Alexandria, Virginia `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee \_22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, Md 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 □ No 24a. Was an 1 Yes 2 □ No Hospital or Attending Physicien: 26. Place of Death Check onl one director, 25. Was case referred to medical examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1 XYes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titl OCME JUNE 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

111 Penn Street Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28018 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death August **Physician** Thomas Anthony Migdalski 10:30 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. | 22, 1942 Baltimore Timonium 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2 F Yrs. New York 083-34-9692 63 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits rthan "risturel", or Items 23a or 28s-f shov the Med cal Examiner must be notified at 1 Yes MNo Harford Bel Air Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 208 E. Timber Trail 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Specialist 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Environmental Compliance U.S. Government 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary (NMN) Laturner Anthony Thomas Migdalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin F. Bress / Personal Rep. 112 S. Main Street, Bel Air, MD 21014 If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stale 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 8-26-05 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licensee McComas Funeral Home, P.A. Mulle un 1317 Cokesbury Road, Abingdon, MD 23a. Part1. Enter the disease, or complications at cause of eshock, or heart failure. List only one cause on each fine. Approximale Interval Between Onset and Death th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician COLON CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Vital is after deam.
ral Director: After this cerus. Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE ٩ 1 ☐ Yes 2 ▼ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 Tes 2 No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) within 2 To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4372

DHMH 17 Rev 1/2001

State Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIO MAHMOOD

AUG 2 6 2005

31. Dale filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien 2 0 0 5

Certificate of Death 28019 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 23, 5:15 P Joseph Frank Miciche August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air 501 Plumtree Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 218-10-8279 87 Director June 23, 1918 | Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Maryland Harford Bel Air 1 Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Plumtree Road 21015 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 le marked other than "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Operator Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Vincent Miciche D'Amico Rose (nmn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) fe 501 Plumtree Boad, Bel Air, Maryland 21015

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

Date

20c. Cation · City or Town, State <u> Dorothy Augusta Miciche - Wife</u> 20a. Method of Disposition 5 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Hilltop Service Corp. 8-25-05 \* 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 40 412 /Medical Due to (or as a consequence of): Examiner THEROSCLEROSIS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a cor Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NPERTENSION 1 Pes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 1 ☐ Yes 2 D No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending 1 Latural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a
To the Funerel D
completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAIR Md 21014 1208 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 For State Registra 28020 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician August 21, 2005 Mary Jane Moser 3:26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center HILDOLLS

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

Sept. 14, 1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 💢 F Indiana 577-26-3986 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State e filed within 72 hours after death with the Marylan II Hygiene.
other than "natural", or Items 23e or 28a-1 show vent, the Medical Examinan must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21403 United States 2 Skippers Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ॲ Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Applied Physics Administrative Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth. any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be Lora Birch Robert Stirling 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 138 Riverview Avenue, Annapolis, Maryland 21401 Joseph D. Moser / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 24, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2005 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home / Rockville, Inc. 21. Signature of Fun al Service ticensee CANSI M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Bifter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 charic **Physician** gitilas WERS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Anoronia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) Box 68760, attending physician - WOU 3 Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year ρ 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No P.0 detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🗂 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; al or Attending P s after death. Il Director: After id in by the funera 1 Matural 5 Pending investigation М 1 Tyes 2 □ No 2 Accident 6 Could not be determined 3 🗌 Suicide To the Hospital or Atte within 24 hours after der To the Funeral Directo completely filled in by the Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WD 46465 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 135 IN/Omes 7479 Alon 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar

	-	For State of Maryland / Departm Certific	nent of Health and M cate of Death	lental Hygid	2005	28021
Physician	n	Decedent's Name (First, Middle, Last)  Charles Francis McMorrow		2. Date of Death Month August 19	Day Year	3. Time of Death
/Medical			City, Town, or Location of Death	1148450 -	4c. County of Dea	
Cxamine	٠.	Suburban Hospital	Bethesda		Montgo	mery
Funeral			Under 1 Year If Under 24 Hrs. hths Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bii	thplace (State or Foreign ountry)
Director		019-12-3692   TAIM 207   85 Yrs.		Aug. 4,	1920 Mas	sachusetts
and *	-	Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryl 1 sho	5	Maryland Montgomery Be	ethesda			1 ☐ Yes 2 ☒ No
the 28a-	5		of, Zip Code	100	g. Citizen of What C	ountry?
and 21215-0036  be filed within 72 hours after death with the Marylan hat Hygiene. Indother than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at the Commissed by Eineral Director	5	4400 East West Highway #303	20814	1	United St	ates
death	Der	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Damed Forces? 11. Marital Status 12. Marital Status 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	
36 or Re	2	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	es 212 No Specify:	1110211, 0101,	1	White
21215-0036 ad within 72 hours all giene. or than "natural", or the Medical Exam . The Medical Exam	0	3 Wildowed 4 Divorced Year or Dates:	Ularat Octobration			
21215-00 ed within 72 hou ygiene. Per than "natura it, the Medical Et. Completed	Jete	(Specify only highest grade completed) (Give kind of life, DO No	Usual Occupation of work done during most of work OT use retired)	ino	Sb. Kind of Business ${ m ndustry}~ \&$	•
1 with	E	Flementary/Secondary (0-12) College (1-4or 5+)	ing Engineer		Consultan	
ind in the tal Hyg d other event.	9 0	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28s-1 show aumatic event, the Medical Examiner must be notified at To Re Commissed by Euroral Director	0	Charles Joseph McMorrow	Edith J	ane Flou	d	
Maryland nd 2 should be file tith and Mental Hy 27 is marked oth r traumatic event			dress (Street and Number or Run		•	
S, N and fealth m 27 her fr	- 1		st West Highway			
Baltimore, semit. Pages 1 at Department of Hea mportent: If tem my injury or other mine.		1X Burial 2 □ Cremation 3 □ Removal from State Arlington N	v or other place)	- 20	oc. Location - City of	Virginia
Itimer ritmer njury	i	Cemetery	200	05 1	-	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic events.		M00198 Robe 7557 N	ne and Address of Facility rt A. Pumphrey Wisconsin Ave.,	Funeral Bethesda,	Home/Cha MD 20814	se, Inc.
- 3		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)  Coronary Artery Dis	ease			7 Years
/Medical Examiner		Due to (or as a consequence of):				
	- G	Sequentially list conditions, I any leading to immediate  Due to (or as a consequence of):				
Sold Lie of Sold L		all any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
exec exec	EX	resulting in death) Last  Due to (or as a consequence of):				
58760, 4 ficate be executed physicien and s the buriat-transit	ca	d				
C 68 antifica antifica antifica	Med	IF FEMALE:				
Ses. P.O. Box 6 ses that the death certificated by the attending be detached for use as by Physician/Me	an	23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ector	pic pregnancy		23d. Date of de Month	elivery Day Year
O. I he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Othe	er (specify)			,
ed by deta	5	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
Cords, P.O vrequires that the been signed by the should be detached by the physical part of t		Diabetes Mellitus, Hypertension		1 🗆 Yes	2⊠No 3□P	robably 4 Unknown
Scord aw required as been size the size	Completed			24a. Was an	24b. Were a	utopsy findings available
The law page 2 st	Ē			autopsy performe	ed? death?	completion of cause of s 2 No
Vital B	യ ി	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)		
A state of	0	1 XYes 2 No Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3		me 5 🗆 Residen	ce 6 Other (Spe	ecify)
Sion of tending Physical Corrected to the funeral di	5	27. Manner of Death 1 28natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury Injury	Work?	28d. Describe how	injury occurred	
Division or Attending after dearth. The fune in by the fune or the fune in by the fune or	Cal	2 Accident investigation 3 Suicide 6 Could not be		294 Lanation /Ctra	at and Number of C	humi Davita Mumbas
DIVI	Certification;	4 Homicide determined determined building, etc. (Specify)	actory, office	City or Town,		tural Route Number,
		29a. Certifier  (Check crity  1 ☑ Certifying Physician: To the best of my knowledge, death occu  2 ☐ Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place,	and due to the cau	ise(s) and manner a	s stated.
To the Hos within 24 h Completely	Medical	one) 22 Institute Charles on the basis of examination and or investige and manner stated.	29c. License number		d. Date signed (Mon	
T con		M. D. Chanter and	D21115		ugust 20,	-
M.	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		A		*
$\int_{\Omega}$		Lee R. Pennington, M.D. 10215 Fernwood	Road, Bethesda	, Maryla	nd 20817	
State Registra		AUG 2 6 2005 32. Refistrar's Signature.	ile			
A STATE OF THE STA	1.5					

State of Maryland / Department of Health and Mental Hygien 2005 28022 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Year **Physician** 2125 HAROLD RICHARD McVICKER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROSEDALE BALTIMORE FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, OCT 4, 19 9. Birthplace (State or Foreign Country) WEST VIRGINIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1√2 M 2□ F 213-36-5257 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, it is medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE MD. N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 UNITED STATES 6600 GARY AVE. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □YYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) 8TH College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Importent: If item 27 is marked other that any injury or other traumair. CARPENTER UNION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VIRGINIA SAFFLE DORSEY JAY McVICKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6600 GARY AVE., BALTIMORE, MARYLAND 21224 MAXINE RADLOFF/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8/29/05 FALLS CHURCH, VIRGINIA NATIONAL CREMATORY \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licenses 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Approximate Interval Between Onset and Death death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or co-shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA 2 nours after death.

nerel Director: After this

filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD RES 00000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237 Dr. SASHA MACHALA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 ZUUD Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 28023 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08 23 Day **Physician** NAY LETTY 2005 9:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD 7. Age (In yrs. last birthday)

Norths Days Hours Min.

Norths Days Hours Min. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Director 235-22-5551 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28e-f show Examine must be notified at 1 Yes 2 No Director Harford Md. Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 Fallston Road filed within 72 hours after death Funeral 21047 U.S.A Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "netural, or 1 ☐ Yes 2 ☑ No Specify Specify: Completed by white 3 N Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) self-employed restaurant 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o Oliver Powell Mary Hilling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1300 Fallston Road, Fallston, Md. 21047 James Nay/son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 importent: i any injury o 8/26/2005 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Highview Mem. Gdns. Fallston, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 100 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately a shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Churc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No Certification: To 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 90508524,200 1)32256 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN, 615 W. MACPHAIL ROAD, BEL AIR, MD 32. Signature 31. Date liled (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 2 6 2005

State of Maryland / Department of Health and Mental Hygieney 28024 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 400 Irene Nelson 0 Rosemary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Hosfita 50 M 01 62/1 110 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X 219-26-1728 66 Director Maryland March 8,1939 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiena. Important: If item 27 is marked other then "nature!; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Middle River Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U.S.A. 46 Right Wing Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: <u>გ</u> 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ann Melnick Nicholas Loizos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Debra Hutson (Daughter) 46 Right Wing Drive, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory, Inc. Aug. 29, 2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Fastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Sarvice Licensee Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician COLITI Sch disease or condition resulting in death) /Medical Due to (or as a consequence of): a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown seta has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 22 No 2□ No 1 Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) A No Other: 1 Yes 1 🗹 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tad PU 9 000 200532. Redistrar's Signature Square DIII et OAKLIA 6 State Registrar

e 1500, Rosenar

			1- State of Maryland / Dep	artment of Health and M rtificate of Death	ental Hyg	giene 2005	28025
			Decedent's Name (First, Middle, Last)		2. Date of Dea Month		3. Time of Death
П	Physicia /Medic		Reva Genell Nelson		August	9 2005	8:15p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
п			John Hopkins Elder Care	Edge Mere		Baltimor	re
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Months Days Hours Min.	8. Date of Birth (Month, Day	9. Birt	hplace (State or Foreign untry)
	Director		212-26-3711		10/5/	27   VA	1
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
	daryl f sho	៦	MD Baltimore Edge Me				1 ☐ Yes X☐ No
	the 1	rect	MD Baltimore Edge Me	10f. Zip Code		10g. Citizen of What Co	untry?
	with Ba or	0	2829 Lodge Farm Rd.	21219		USA	,-
	death rns 2;	Funeral Director		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto			ncan Indian,
က	or Iter	Fur	1 ☐ Never Married 2 ⚠ Married 1 ☐ Yes 2 ☐ No	v	Rican, etc.)		
Ö	ral', c	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		SpecifyWh1	.te
5-0	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show Jical Evarril et must be nutilied at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	na	16b. Kind of Business/	Industry
21	within ene. than "	npl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	e filed within al Hygiene. i other than '			tress		Restauran	ı <u>t                                    </u>
Maryland 21215-0036	init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ortment of Health and Mental Hygiene. ortant: If tiem 27 is marked other than "natural", or liems 23a or 28a-f show injury or other traumatic event, the Medical Examirer must be multilied at a.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		Maiden Sumame)	
7	2 should be and Mental Is marked c	<sup>L</sup>	John Gwaltney	Cora Ba			
Nai	12 sh h and 7 Is n traun			ng Address (Street and Number or Rura			
	ss 1 and of Health item 27 other to		Mary Ahmer (Granddaughter) 290  20a. Method of Disposition 20b. Place of Disp			Dundalk, M 20c. Location - City or	
Baltimore,	iges if it		1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State	matory or other place)			
tir	rt. Partmer rtant rtant njury		`4 □Donation 5 □Other (Specify) Bayview	Crematory 8/2	3/05	Dundalk,M	D
Bal	permit. Pages 1 Department of H Important: If ite any injury or ot			2. Name and Address of FacilityWes.			
				007 Eastern Ave			3 1 Approximate
П	ai . =00		23a. Part1. Enter the disease, or adiplications that caused the John. Do not en shock, or heart failure. List of one cause on each line.	ter the mode of dying, such as cardiac o	i respiratory arr	est,	Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Dement				Zyrs
	Examiner		Due to (or as a consequence of):	no Deseces			5
		-	Sequentially list conditions, france, leading to immediate Due to (or as a consequence of):	~) DC 4 C5 3			2 Drs
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
_,	al-tra	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit						
89	tificate ig phy as the	edic	V.				
Вох	9 ip 8	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
	death e atten	icla	in the past 12 months?  1 Ves 2 Petal death 5[	□Ectopic pregnancy □ Other (specify)		Month	Day Year
0	t the	hys	9 Unknown		_		
s, P	w requires that the s been signed by the should be detache	y P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ğ	quire an sig				1 □ Y	es 200€No 3⊡Pro	obably 4 Unknown
000	aw Is b	plet			24a. Was a		topsy findings available
Vital Record	ding Physician: The lav h. After this certificate has funeral director, page 2	Completed			autops perform	med? death?	ompletion of cause of
ita	lan: rtifica stor, p	ø	25. Was case referred to medical	26. Place of Death			2010
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Hon	ne 5 Reside	ence 6 ther (Spec	lify)
Division of	ng PI ter th		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at 2 Work?	8d. Describe ho	ow injury occurred	Civing
<u>0</u>	Attending ir death. ector: After by the fune	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			traility
ĭ₹	for Attencater death Director: In by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 2	8f. Location (St City or Town	treet and Number or Ru	ral Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Ç					
	To the Hospital of within 24 hours at To the Funeral Discompletely filled in	edical	29a. Certifier (Check only (C	h occurred at the time, date and place, a	nd due to the ca	ause(s) and manner as	stated.
	the Prin 24		one) and manner stated.				``
	viti To Con	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month	, Day, Year)
ŀ			M. Whelveyno	245757		Jugust ?	25, Zoos
			30. Name and address of person who completed cause of death (Item 23a) (Type, Matt M(NGSnEy 4646)	Print) Eastern Are	Bala	r MD 2	1224
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 6 2005  32. Segistrar's Signature	Soll )			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 28026 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Perez 12:15 PM August 10, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 06/17/1960 45 131-52-4643 Yrs Puerto Rico Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28e-f ehow the Medical Examiner must be notified at 1 Pres 2 No Worcester Ocean City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 21842 205 Dorchester Street United States death. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Hispanic þ 3 ☐ Widowed 4 ☐ Divorced ruerto R "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hote1 Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Specialist 12 ilth and Mental Hygier 27 ie marked other ti r traumatic event, Ib 17. Father's Name (First, Middle, Last) parmit. Pages 1 end 2 should be lift
Department of Health and Mental Hy
Important: if Item 27 is marked oth
eny liqury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Perez Jose Tomasa Perez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti Shea 11121 Grays Corner Road Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug 24 1 □ Burial 2 ☑ Cremation 3 □ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2005 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dilated avaiomyopa /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, oulcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death signed by the e o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No should 24a. Was an certificate has t irector, page 2 s autopsy performed? 2 No 1X Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ XYes 2 No 1 ☐ Inpatient 2X ER/OutpatienI 3 ☐ DOA his After thi 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: / 3 ☐ Suicide 6 Could not be 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 11, 2005 pleted cause of death (Itom 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 t ) rugs TIL 31. Date filed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 1/2001

32. Registrar's Signature

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygien 2005 28027 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Evelyn Charlotte Petersen August 24, 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 28, 10 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🎛 F 326-01-4647 90 Yrs. Director 1915 Kansas Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itams 23a or 28a-f ehow traumatic evant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5020 Druid Drive 20895 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Word Processing Typist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 Is marked off Arthur C. Anderson Myrtle Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Luther Lee Budd/Husband 5020 Druid Drive, Kensington, Maryland 20895 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
Montgomery
Crematorium, Inc. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ò August 26, permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2005 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 23a. Part1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nours /Medical Due to (or as a consequence of): Examiner irfection tract Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 1 Tes 2/2 Attending Physician: 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 ER/Outpatient 3 DOA 1 🗌 Yes within 24 hours after death.

To the Funeral Diractor: After thi
completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Płace of łnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 24, 2005 D59738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive Rockville, MD 20850 9901 Alicia T. MISTRY 32. Aggistrar's Signatur 31. Date filed (Month ADG Year) State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,  $ot \mathcal{K}$ 

Hygiene2	0	0	5	2	8	0	2	-

yland P.A.

/00			For	State of Ma	aryland /	Depa	artment of H	lealth and N	lental Hy	giene)	105	280	128
		•	State     Registrar			Cei	tificate of I	Death		Reg. No.		Sun C	
			1. Decedent's Name (First, Middle, La	•					2. Date of De		Vear	3. Time o	
	Physicia /Medica		Stephanie	Ann Ra	dcliff	e			Augu	st 23,	2005	2:16	Рм
	Examine		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Death			unty of Death		
¥			Baltimore Washing	gton Medica	1 Cent	er	Glen Bu	rnie		A	inne Ai	rundel	
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age 1 □ M 2 □ X F	in yrs. last 42	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da NOV. 0	th ly, Year) 9 1962	9. Birth Cou	place (State Intry)	
	Б .		Usual Residence of Decedent		to- Ch. T							404 Incide C	On a I Seeding
	s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Health and Mental Hygiene. I health and Mental Hygiene from 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examiner must be notified at	to	Maryland Anne A	rundel	10c. City, To	own or Lo		sadena				10d. Inside C	2∭No
	7 28.	lre	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?	
	th with	Funeral Director	8431 Alvin Road					21122			USA		
	dee ge	ner	11. Marital Status	12. Was Decedent E	Ever in U.S.	13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	D- 14.	Race - Amer Black, White		
920	urs after al', or it	<u>م</u>	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo		1 ☐ Yes 2∑ No	Specity:	Triodin, oto.,			nite	
21215-0036	n 72 ho	Completed	15. Decedent's E (Specify only highest gr.	ade completed)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ring	16b. Kind o	of Business/I	ndustry	
12	within iene. then	d o	Elementary/Secondary (0-12)	Coflege (1-4or 5	+)		Drive			Sch	ool Bu	S	
	Hyg othe	Bec	17. Father's Name (First, Middle, Last	·)	1			18. Mother's Nam	e (First, Middle	, Maiden Sur	name)		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other then "r	10 8	Joseph F. E	rnest			The state of the s	Linda	Fil'	ler			
ar	short short		19a. Informant's Name/Relationship (	Type, Print)	1	9b. Mailir	ng Address (Street	and Number or Rui	al Route Numb	er, City or To	wn, State, Zi	ip Code)	
Σ	alth alth	- 1	Philip G. Radclif	fe Jr. (sp	ouse)			Road, Pas	sadena,	MD 21	122		
Baltimore,	permit. Peges 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1		sition (Name of matory or other place on Cemete)	1	<sup>Data</sup> 27 005		on - City or T Runnia	own, State , Mary	land
=======================================	artme ortar injur		21. Signature of Funeral Service Lice		Julen		. Name and Addre			ings F			
Ba	permi Depa impo any i		1 Sund	Xing !				ıntain Ro	ad, Pasa	adena,			1 . / \
		Ì	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each in	the death. D	o not ent	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest.		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	a HEAD	AND			WRIES				Onset and	Death
	/Medical		resulting in death)	Due to (or as	a consequence					-			
	Examiner		Sequentially list conditions	b		GI.							
		ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Que to (or as a	a consequent	ra offy.							
X	xecuted and	xamln	Cause (Disease or injury that initiated events resulting in death) Last	С.									
7	× " -	×	resuming in death/ Last	Due to (or as a	a consequenc	ce of):							

To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien completely filled in by the funeral director, page 2 should be detached for use as the buria Completed by Physician/Medical Be Medical Certification: To

Division of Vital Records, P.O. Box 68760

	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown

eath

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗆 Inpatient

28a. Date of Injury (Month, Day Year)

8/23/05

3 □Ectopic pregnancy 5 □ Other (specify) \_\_\_

3 DOA

М

23d. Date of delivery Month Day

1 Yes 2 No

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

Year

24a. Was an autopsy performed? 1 Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1. ■ Yes 2 □ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred DRIVER OF CAR IN COLLISION 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROAD

2 X ER/Outpatient

28b. Time of

1:45 8

Injury

RT 100, WEST OF RTZ, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as states.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Xes 2 □ No

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

1 Tyes 2 No

August 24, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUB 10. ANA MD 111 Penn Street, Baltimore, Maryland

State Registrar 31. Date filed (Month, Day, Year) AUG 2 6 2005

5 Pending investigation

6 Could not be determined

32. Registrar's Signature

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygien 2005 28029 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Josephine T. Rupprecht August 2005 11:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4h. City Town or Location of Death Examiner 4c. County of Death Genesis Perring Parkway Nursing Center Parkville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Director 214-03-6419 Maruland Usual Residence of Decedent with the Maryland Show 10b. County 10c. City. Town or Location 10d. Inside City Limits treumatic event, the Mudical Examinar houst be notified at Funeral Director 1 Yes 2 No Maryland N/A Baltimore 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 603 S. Ann St., Apt #611 21231 U. S. A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 X Widowed 4 □ Divorced Specify. White 15. Decedent's Education
(Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Pages 1 and 2 should be Department of Health and Mental Importent; if item 27 Is marked any injury or other treumatic evone. Salvatore Farace Concetta Culotta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adeline Mauer (Sister) 3303 Cardenas Ave., Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lorraine Park 8/24/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Reprovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 250 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059423 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samarran Hisport & Pot Building #303 Bellinge 32. Registar's Signature State AUG 2 6 2005 Registrar

			1 - For State Registrar	State of Mary		artment of H			giene Reg. No 0	)5	280	30
	Physici		Decedent's Name (First, Middle, Las     RACHEL	t)		ROHN		2. Date of De	24 <sup>Day</sup> 200	<b>5</b> Year	3. Time of 8:30	Death AM
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	1	4c. County			
			1799 EAST JEFFER	SON STREET	#2131	ROC	KVILLE			MON	TGOMERY	Y
	Funeral Director		0,0 02 ,200		yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da SEP. 3	1919	9. Birth Cou	place (State or ntry) AUSTR	r Foreign I A
	land		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ocation				- 1	10d. Inside Cit	v Limits
	ath with the Marylan 23a or 28a-f show	to	MD MON	TGOMERY	ROC	KVILLE					1 X Yes	2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	/hat Cou	ntry?	
	23a c	rai	1799 EAST JEFFE	RSON STREET	#2131		20852				USA	
	er deg	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No o Rican, etc.)	- 14. Race Blac	- Ameri k, White,	can Indian, etc.	
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:		1□ Yes 2∏ No	Specify:		Specify	:	WHITE	Ξ
ò	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show Ite Medical Examener must be positive an	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Bu	siness/In	dustry	
215	within 7 lene. than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired,	) )	King				
72	filed w Hygier other th		17. Father's Name (First, Middle, Last)	4	IEA	CHER	18. Mother's Nam	o (First Middle	EDUCAT			
Maryland 21215-0036	o d a b	To Be	MAURITZ		BRENNE	R	JOSEPH:				CKELBAC	าม
ary	s 1 and 2 should I f Health and Menitem 27 Is marker other traumatic	-	19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street a						
	and 2 ealth a n 27 Is		RUTH ROHN / DAU	GHTER	184	STRATHEAR						, 20 .
Baltimore,	Pages 1 a nent of Hea nt: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 💢	Removal from State	-	natory or other place	.	Date	20c. Location -	-		
Ħ	+ 문합금		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service License</li> </ul>		NEW MONTE	FIORE CEN 2. Name and Addres	1. 08/25	5/2005	PINELAV	IN, I	1Y	
Ba	permi Depa Impo any is		Rocato/	Jun-	<b>S</b> 8	900 REIST	ERSTOWN I	ROAD - P	PIKESVIL			)8
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the ne cause on each line.	death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rrest,		Approximate Interval Betw Onset and D	veen
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Acute	Zene	1 201	wa_				Onot and D	
	Examiner			Due to (or as a cor	nsequence of):							
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):							
1	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с								
8760,	cate be executed oblysician and the burial-transit		Tooling in doubly add	Due to (or as a cor	nsequence or);							
687	death certificate e attending phys d for use as the	edicai	`	d								
Вох	eath certific attending p	M/UE	200. Was decedent program	23c. If yes, outcome of pr 1□Live birth 2□		Ectopic pregnancy			23d. Date	of delive	ery	
O. B		Physician/M	in the past 12 months? 1 □ Yes 2-□ No 9 □ Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)			Mon	th	Day Ye	ear
<u>P</u>	requires that the de een signed by the a hould be detached t		Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause give	in in Part I	23e Did to	bacco use contri	bute to th	ne cause of de	ath?
ds,	Se Libe	d by	He senten son	,	a a a a a a a a a a a a a a a a a a a	ido.iying daado giro			res 2€No			
CO	aw require s been sig 2 should b	ojete	C - 500 2 - 1	Ed Feli	2			24a. Was		ere auto	psy findings av	vailable
Vital Record	The faw cate has b page 2 st	Completed	Congestive 17	7:5	1. 10			autop perfor 1 Yes	med? pi	for to con	npletion of cau 2□ No	
/ital	ician: Th certificate rector, pag	BeC	25. Was case re erred to medical examiner?	5. 72.	ace 14	ver.s	26. Place of Deal				20110	
of \	Physician: this certific ral director,	<u>٩</u>	1 ☐ Yes 2 No		2 ER/Outpatien	t 3 DOA Othe	r: 4 Nursing Ho				י לבניבתים	ich
on	ding I h. After funer	tion	27. Manner of Death  Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Work	at ? ′es 2 ∐No	28d. Describe h	ow injury occurre	id	2	
Division	Atten r deat ector: by the	ifica	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	At home, farm, str		55 20.10	28f. Location (S	Street and Numbe	r or Rura	l Route Numb	er,
ā	tal or rs afte al Dir	Certification:	4   Holfficiae	building, etc. (S	oecity)			City or Tow	m, State)			
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier (Check only one) Certifying Phy	sicien: To the best of my ner: On the basis of examination manner stated.	knowledge, death mination and/or inv	occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the d red at the time, o	cause(s) and man date and place, a	ner as st	ated. the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed	(Month,	Day, Year)	
1	. 7		) > <	Distors		2005			8/24/0	5-		
	10		30. Name and address of person who	ompleted cause of death	(Item 23a) (Type,	Print) 1801	Z. 36866	2 27				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	signature	ROCK	2/10/	W) 5	N 75-72			
	Registr		AUG 2 6	2005 Maria	J. B. A	facely						

State of Maryland / Department of Health and Mental Hygien 2005 28031 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 24, 2005 20 **Physician** Leach Ralev Daniel 3:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 0 (Month Day) Year 1948 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Marviand 1 XM 2 ☐ F 216-50-6814 56 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b County in then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 1 Tes 2 No Baltimore Lutherville MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 U.S.A. 325 Gailridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education grade completed) (Specify only highest College (1-4or 5+) Elementary/Secondary (0-12) E A Engineering Environmental Engineer is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth eny linjury or other treumatic event QRE8. Be Minnie Raley George Ε. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3810 Donerin Way, Phoenix, MD 21131 John C. Ralev-brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillton Service Corp 8/26/05 Towson, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE ERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed CANCER TONGUE that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, CHRONIC LYMPHOCYTIC Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2X No this certificate 1 Yes 2 🗆 No 1 Yes or Attending Physicien: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient Certification: To 1 Yes 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerei L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELLONA LANE, SUITE 216, TOWSON, MD 21204 8415 AMIT KHOSLA, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

AUG 2 6 2005

State of Maryland / Department of Health and Mental Hygiene 2005 28032 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Robert G. Rothwell 23 2005 August /Medical 1400 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7110 Amy Lane Bethesda Montgomery 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12XM 2□F Director Yrs. 111-16-9214 83 Sept. 22, 1921 New York Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location al Hygiene. I other than "natural", or Iteme 23a or 28a-f ehow vent, Ita Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Montgomery Maryland Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen ol What Country? 7110 Amy Lane 20817 Completed by Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. iled within 72 hours after 1 ⊠Yes 2 No If Yes, Give Year or Dates: 42-65 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Certified Public Accountant Federal Government 27 is marked other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be to and Mental F ဥ Charles Irving Rothwell Edith M. O'Brien 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7110 Amy Lane, Bethesda, Maryland 20817 Sylvia A. Rothwell/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 25, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 300 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01356 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Gangrene feet with Septicemia Months /Medical Due to (or as a consequence of): Examiner Dementia with Lewy Bodies Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of): certificate be executed Due to (or as a consequence of) inding physicien use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause ol death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 2 ☑ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 🖾 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA this : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 XNatural Injury 5 Pending 1 Tyes 2 No 2 Accident investigation M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \tag{Homicide} ă To the Hospital o within 24 hours af To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier Attende Physleiga 29c. License number 29d. Date signed (Month, Day, Year) UAD10/050097 5× 0 Tuch 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) National Naval Medical Center Kenneth G. Pu,h, MD, CDR MC USN, 8901 Wisconsin Avenue, Bethesda, Maryland 20889 32. Resistrar's Signature 31. Date filed (Month, Day, Year) AUG 2 6 2005 Coard

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

68760,

Box

P.0.

Records,

Division of Vital

			For State Registrar	State of Maryland / [	Depa <i>Cei</i>	artment of F tificate of	lealth and <i>Death</i>	Mental Hy	/gien Reg. N	2005	28033
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of D	eath	ay Year	3. Time of Death
	/Medic Examir	al	4a. Facility Name (If not institution, give str		SR		r Location of Dea	AUG th	4	c. County of Death	624PM
		Ç.	GOOD SAMARITA			BALTI				BAUTIMOR	ZE CMY
	Funeral Director		225-28-0/9/	7. Aĝe (In yrs. last bin	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		irth a <i>y, Yeal</i> 924	9. Birthp Cour NORT	place (State or Foreign http) 'H CAROLINA
	rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Lo	cation				1	0d. Inside City Limits
	Ba-1sh	Director	MD. N/A	BALT	IMO	RE					1. Yes 2 □ No
	with the	Dire	10e. Street and Number 6017 CHINQUAPIN P	ADVITAN		10f. Zip Code	20		_	itizen of What Cour	ntry?
	death	nera		Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H	ispanic Origin? (	Specify Yes or N		USA 14. Race - Americ	
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1XYes 2 □ No If Yes, Give Year or Dates:		Yes, specify Cuba	Specify:	no Hican, etc.)		Black, White, Specify: BLA	
21215-0036	"natur	leted	15. Decedent's Educa (Specify only highest grade of		Deced (Give	ent's Usual Occup kind of work done OO NOT use retired	ation during most of wo	orking	16b. i	Kind of Business/Ind	dustry
212	filed withir Hygiene. othar than ent, the M	omp	Elementary/Secondary (0-12) -12-	College (1-4or 5+) -0- M		TENANCE S			HOI	USING AUT	HORT <b>T</b> V
nd	be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last)					me (First, Middle			HORLII
Maryland	2 should be and Mental is marked (sumatic ev	<sup>o</sup>	CLARENCE E. REYNO  19a. Informant's Name/Relationship (Type		Mailin	Address (Street		HAMILTO		or Town, State, Zip	0-4-1
Ž ≅	t and 2 s lealth ar im 27 is ther trau		THEOPHILUS A. REY	NOLDS, JR(SON)	601	7 CHINQUA	APIN PKW	Y. BALTI	MOR1	E, MARYLA	ND 21239
Baltimore,	permit. Pages 1 and Department of Heall Important: If itam 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	loval from State cemeter	y, crem	sition (Name of atory or other place		Date		ocation - City or To	
	nit. Pa artmen ortant: injury e.		' 4 □ Donation 5 □ Other (Specify)  21. Signature of a state of Service Licensee	GARRISO TONATHAN D. HTB	N F	OREST VET	ERANS 8	-30-2005	OW.	INGS MILL	S, MARYLANI
Ã	Depar Impo any ir		Josepha	O Hibra						RE, MARYL	AND 21217
	*		23a. Part 1 Enter the disease, or complica shock, or heart failure. List only one	ions that caused the death. Do n cause on each line.	ot ente	r the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of		2DIAL	INFA	CTION	1		Onset and Death
	Examiner		Sequentially list conditions, b.								
	uted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):						
oʻ	ificate be executed g physician and as the burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of	f):						
68760	icate b physic s the bi	edical	d			-					
Box	leath certific attending p	an/Me	250. Was decedent pregnant	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3□	Ectopic pregnancy				23d. Date of deliver	y
P.O. E	The law requires that the death cert tee has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death 9 Unknown		Other (specify)				Month	Day Year
S, T	w requires that the de been signed by the s should be detached	by Pł	Part II. Other significant conditions contri	outing to death but not resulting in	the un	derlying cause give	n in Part I.	23e. Did t	obacco	use contribute to the	e cause of death?
ord	requir	eted						1 🗆 '	Yes 2	□No 3□Proba	
Vital Records,	The law cate has page 2 s	Completed						24a. Was autor perfo		I prior to com	sy findings available apletion of cause of
VIta	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	site (		011		ath (Check only o	-/->_	To res	2 140
ō	y Phys ar this c	7: To		28a. Date of Injury 28b. Ti	me of	3□ DOA Othe 28c. Injury Work	4 🗀 Nursing F	lome 5 Resident		6 Other (Specify)	)
Sion	uttanding F death. ctor: After y the funer	atlo	Natural 5 Pending investigation	(Month, Day Year) In	jury		? ′es 2 □ No				
DIVISION	el or Att s after d l Diract d in by t	Certification	3 Suicide 6 Could not be 4 Homicide determined	<ol> <li>Place of Injury - At home, fare building, etc. (Specify)</li> </ol>	m, stre	et, factory, office		28f. Location (S City or Tox	Street an vn, State	nd Number or Rural a)	Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical (	29a. Certifier (Check only one)  Certifying Physici (Check only one)	an: To the best of my knowledge, On the basis of examination and and manner stated.	death /or inve	occurred at the timestigation, in my op	e, date and place inion, death occu	, and due to the gred at the time,	cause(s) date and	and manner as sta d place, and due to t	ited. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. License	number			te signed (Month, D	
	,7		20 None and	es (Mo		95	8733		AU	9 23 ,2	05
	10		30. Name and address in person who comp	letegicause of death (Item 23a) (1 560 L Locu	1	PAVEN	BLUG	BA	UTI	MORE MY	0 21239
2	Sta	e	31. Date filed (Month, Day, Year) AUG 2 6 2005	32. Registrar's Signature						-	

CH	AEL SUL	LIV.	VAN State o   State Unpend Item 23a&27   Registrar	f Marylan per me C	d / Depa 847	artmer -13-0 rtifica	t of H 5 ta: e of L	ealth a Death	nd M	ental Hyg	ien <b>2</b> 0 0	15	28034	
	Physici	an	1. Decedent's Name (First, Middle, Last)  Michael Sulli							<ol><li>Date of Deat Month</li></ol>	h	Year	3. Time of Death O741 A M	
	/Medic Examin	al er	4a. Eacility Name (If not institution, give street and nur 307 MOUNTAIN RIDGE COUR	nber) T		4ь. City GL	Town, or EN BU	Location of RNIE	Death		4c. County of ANNE	of Death		
	Funeral Director		5. Social Security Number 226-96-3840	7. Age (In yrs. i 4	- 1	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth JULY 28	<sup>r</sup> 9960	9. Birth Cou	place (State or Foreign ntry) MD	
	th the Maryland or 28a-1 show	irector	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Arundel  10e. Street and Number	10c. City	, Town or Lo		p Code	Burn	iie	1	0g. Citizen of W		10d. Inside City Limits 1 ☐ Yes 2 ☐XNo	
336	be filed within 72 hours after death with the Maryland fal Hygiene. d other than "natural", or Itama 23a or 28a-1 show avant, tra Madical Examinar musi be mullied at	by Funeral Director	307 Mountain Ridge Cout  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 X Divorced  1 Yes, Gir	edent Ever in U. prces? 2 🔯 No ve			dent of Hi	21061 spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto f	cify Yes or No- Rican, etc.)	Black	USA  14. Race - American Indian, Black, White, etc.  Specify: White		
121215-0036	filed within 72 hoo Hygiene. Ither than "natura int, Ita Medical E	Completed												
Maryland	should be filed nd Mental Hygi n marked other umatic avant, I	To Be	John F. Sullivan		10h Maille	na Addros	s (Street)	Edna	a		Reinke		o Codel	
	t end 2 s Health ar tam 27 la		19a. Informant's Name/Relationship (Type, Print)  Candy P. Wharton (Sis:  20a. Method of Disposition  1 Burial 2 DCremation 3 Removal from	State 20b. P	504 lace of Dispo	Kent esition (Na matory or	ROa	d, G1	en B Aug.⊓	urnie, M ate 25	1D 21060 20c. Location - 0	) City or T	own, State	
Baltimore,	permit. Pages Depertment of I Important: If its any injury or o		4 Donation 5 Other (Specify)  21. Sign turn of Funeral Service (Igensee	Met	tro Cre	2. Name a	nd Addres	s of Facility			s Funera	I H	Maryland ome, P.A. 122	
	Pnysician		23a. Part. Enter the disease, or complications that shock, or heart failure. List only one cause of a limmediate Cause (Final disease or condition	each line.						r respiratory arrovant		se	Approximate Interval Between Onset and Death	
8760,	Medical Examiner sicien and partial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a conseq (or as a conseq (or as a conseq	uence of):									
Box 6	death certificafe e ettending phy d for use as the	Physician/Medic	in the past 12 months?	tcome of pregna birth 2 □ Feta nant at time of d own	I death 3	]Ectopic   ] Other (s	pregnancy				23d. Date Mon		very Day Year	
ds, P.O	uires thef the de n signed by the e	٤	Part II. Other significant conditions contributing to d	eath but not res	ulting in the u	inderlying	cause give	en in Part I.		23e. Did tol	_	bute to 3 ☐ Pro	the cause of death?	
I Records,	The law requires thef the sete has been signed by the pege 2 should be detache	Completed								24a. Was a autops perform	ned?	lere aut nor to co ath?	opsy findings available ompletion of cause of	
on of Vital	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificete completely filled in by the funeral director, pe	To Be		Inpatient 2  of Injury ofth, Day Year)	ER/Outpaties 28b. Time o Injury		28c. Injun World	er: 4 □ Nui	rsing Hor	n Ch ck only on me 5 ☐ Reside 28d. Describe ho	ence 6X10the	· · · · · · · · · · · · · · · · · · ·	fy) AT SCENE	
Division	To the Hospital or Attending within 24 hours after death. To tha Funeral Director: Affer completely filled in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place	e of Injury - At he ling, etc. (Specif	ome, farm, st	reet, facto	ry, office			28f. Location (Si City or Town	treet and Numbe n, State)	or Au	al Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the back only one)	e best of my kno basis of examina oner stated.	wledge, deat ition and/or in	h occurre ivestigatio	d at the tin	ne, date and pinion, deat	d place, a	and due to the c ed at the time, d	ause(s) and mar ate and place, a	nner as nd due	stated. to the cause(s)	
)	To th withir To th compl	Me	29b. Signature and the of certifier	1-1/2-	w		O.C	.M.E		2	9d. Date signed AUG.		, Day, Year) , 2005	
			30. Name and address of person who completed cau  THE WORE MIKIF	11	n 23a) (Type. 1 PENN	STR	EET,	BALTI	MORE	, MARYLAI	ND 21201	-		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 6 2005	Registrar's Signa	MILE AND									

State of Maryland / Department of Health and Mental Hygien 2005 28035 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 24, 2005 **Physician** Catherine Carrie Schwarzman 9:45 P August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Ivy Hall Geriatric Center Middle River 8. Date of Birth (Month, Day, Year) Dec. 8, 1916 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number Funeral Days Hours Months 1 ☐ M 2 X F Maryland 88 219 18 9580 Director Usual Residence of Deceden 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show the Medical Examiner must be notified at 1X Yes 2 □ No Baltimore Director Maryland 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21206 USA 5733 Moravia Rd. 238 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Hems ; 11 Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: Specify: ₽ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cardboard Box Mfg. Cardboard Box Finisher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F la marked ot Daisy Farrar John Hetterich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Stepson) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Ia m any injury or other traum once. 1009 Cherlyn Rd. Baltimore, Md. 21221 Francis J. Schwarzman Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gardens 8/27/2005 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Eacility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23a Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscientic Cardiovascular Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine nding physician and use as the burial-transit Due to (or as a consequence of): Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) detached f Division of Vital Records, P.O. 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2K No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Hospital or Attending Pt 24 hours after death. Funerel Director; After th 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 D43725 25701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 MAHMOUD 201-109 Back Niver Neets Ru 31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 28036 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 24 2005 Anna E. Smith 9:40am /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Hammonds Lane Center Baltimore Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) Sept. 23, 1920 **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Days Hours 215-18-7219 Director 84 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. tnside City Limits the Medical Examiner must be notified at Md AnneArundel Baltimore Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Hammonds Lane or Itema 23a 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify. Specify: White 3℃ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than . Elementary/Secondary (0-12) Cottege (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygienn Important: If item 27 is marked other the any injury or other traumatic event, Italy Ones. Bread Store Manager 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Gruber Myrtle ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 447 East Green Street Westminister MD Michael Huber/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/27/05 OAkLawnCemetery Baltimore MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Homeof Essex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or comblications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to bras a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam physician and the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as attending g IF FEMALE: use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ cate has been signated by page 2 should b Be Completed 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification; To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53462 MD 2 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) 7845 Jude W 31. Date filed (Month, Day, Year) Road Glen Burnie, MA OAKWOOD 32. Begistrar's Signature State Registrar AUG 2 6 ZUUD

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death 28037 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1:07 AM August 22, 2005 Van Curtis Scott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10M 2□F Days Months Hours 58 Director 02/05/1947 212/50/3542 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "naturel", or Items 23a or 28a-f show other treumatic event. The Medical Exampler must be inclined at 1 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 United States 20th Street 421 E. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 AND If Yes, Give Year or Dates: 1. Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 BNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Salvation Army and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Doctor Scott Ola Mae Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Importent: If Item 27 Is I any injury or other treut once. Joseph Scott/brother 443 Ilchester Avenue Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Aug 23 Beltsville, Maryland Chesapeake Crematory 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives underl cremation and Funeral Alternatives

6-1443 | 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PROSTATE CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical as the t the attending IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached Records, P.O. 9 Unknown 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 TUnknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 POther (Specify) HOSPICE 1 Yes 2 No 2 of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide hours To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 l 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D4372 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093 22. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 28038 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST 24 2005 **Physician** 6:40 AM M MINNA NMN SESKIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL INSTITUTE OF HEALTH BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) SEP. 13, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2₩F 79 Yrs. 108-20-7576 POLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County works item 27 is markad other than "naturel", or Items 23a or 28a-f show other treumstic event, the Madical Examiner must be notified at 1 Yes 2 No Director MD KINGS **BROOKLYN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 FOSTER AVENUE 11230 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed withIn 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR DEFENSE CONTRACTS permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any njury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SARVER MORRIS FANNIE ST0FSKY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) STEVEN SESKIN / SON 250 HURLBERT STREET - STATEN ISLAND, NY 10305 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🂢 Removal from State BETH MOSES CEMETERY 08/25/2005 PINELAWN, NY <sup>¹</sup> 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Buneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 24 hrs Intraceremal bleed Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonny empelism requiring anticoagulation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-transit Non-Hodgkin'S

Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🕅 No 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the autopsy performed? 2 🗀 🙌 0 1 Yes 2 2 No 1 Tyes Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/2 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 Not FD43, Bldg 10 10 CENTER DRIVE, BETHESDA, MARYLAND 3 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State MILE 2 6 2005 Registrar

901	.0		1 - For Unpend Item 23	State of 27,28	Marylan a-f pe	d/Depa T me Cei	artment of 1846 8-31 dificate of	lealth a -05 ta Death	and Ment as	tal Hygie	ne 20 (	)5	280	39
		Ш	1. Decedent's Name (First, Middle, Last)						2. D	ate of Death		····	3. Time of	Death
	Physici /Medio		Brenna	n John	Stilso	n					9, 200	Year 15	0915	A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give	treet and numb	er)		4b. City, Town, o	r Location o	of Death		4c. County o	f Death		
			SHADY GROVE ADVENT	IST HOSE	PITAL		ROCKVILI	E			MONTGO	MERY	Z	
	Funeral Director		218-19-3778	7. M 2□F	Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (A	ate of Birth Month, Day, Ye y 30, 1	ar) 984	Cour	lace (State o. htry) y Land	r Foreign
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside Cit	by Limite
	Aaryli sho	5	Maryland Montgome:	cv	1	ockvil:							11⊽7Yes	
	28a-	Director	10e. Street and Number	- 7	100	JCRV II.	10f. Zip Code			100	Citizen of Wh	nat Cour	21	
	Sa or		709 Carr Avenue					350		-	ited S		•	
	death ms 2%	Funerai		12. Was Decede	nt Ever in U.	S.   13. V			nin? (Specify Y		14. Race			
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be invitted at	by Fun	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 ☐ Yes 2] If Yes, Give Year or Date	s? XiNo		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2ሺ No	n, Mexican, Specify:	, Puèrto Rican	, etc.)		White,	etc.	
Š	2 hor	ted	15. Decedent's Edu			16a. Deced	ient's Usual Occup	ation		16b	. Kind of Busi	iness/Inc	dustry	
215	within 72 ene. than 'na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	or 5+)	(Give life. L	kind of work done DO NOT use retired	during most ()	of working					
2	gien gien er th	FO.	12	3-(		Stud	ent				Schoo	01		
Maryland	be filed ital Hygid of other	Be (	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (Firs	t, Middle, Maid	len Sumame,	)		
<u> </u>	should and Men marke umatic	ပ္	George R. Stilson					Kerr	y Watt	erson				
Jar	2 sh and is m		19a. Informant's Name/Relationship (Ty)				g Address (Street							
	and 2 tealth om 27 i		George R. Stilson	/ Fathe	The second second		East Gude sition <i>(Name of</i>	Driv		1				d 2085
وّ	Pages nent of P int: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from Sta	te Cé	emetery, cren	natory`or other plac	e)   A	ugust 2 2005	25.	Location - C	•		
altimore,	it. Pa rtmer rtant njury		4 Donation 5 Other (Specify)		Mont	0 2	Crematorium			_	hesda			
Ba	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License  Muzikella Orom	+	M0130	5   300	Name and Addre Dert A. Pun O West Mont	gomery	Avenue,	Rockvil	kville, le, Mary	Inc. yland	20850-2	2805
			23a. Part1. Erker the disease, or compli- shock, or heart failure. List only on	cations that cause cause on each	sed the death n line.	n. Do not ente	er the mode of dyin	g, such as o	cardiac or resp	piratory arrest,			Approximate Interval Bety	ween
I	Physician		Immediate Cause (Final disease or condition	Mixed d	rug(me	thadon	e,citalo	oram a	ind ola	nzapine	)intox	ica	Onset and D L <b>ion</b>	leath
	/Medical Examiner		resulting in death)		as a consequ									
		ē	Sequentially list conditions, if any, leading to immediate	Dun to /or										
d	rsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ience or):								
	ficate be executed physicien and s the burial-transit	Examin	that initiated events cresulting in death) Last	Due to (or	as a consequ	uence of):								
8/60,	sicier buri	al	L.									ŀ		
	ficate p physics the	edicai												
XOD	et the death certific I by the ettending I stached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcor							23d. Date	of delive	rv	
ň	death e ette d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant	at time of de		Ectopic pregnancy Other (specify)	-			Month		*	'ear
j.	t the by the	hys	9 Unknown	9□ Unknowr	1				-					
ν, Τ	w requires thet the s been signed by the should be detached	by P	Part II. Other significant conditions con	tributing to death	but not resu	ilting in the un	derlying cause give	en in Part I.	2:	3e. Did tobacc	o use contrib	ute to th	e cause of de	ath?
ğ	aquire en siç ould b									1 ☐ Yes	3 No 3	☐ Proba	ably 4 ⊟U	лкпо <b>w</b> п
ecora	> 0 70	ompieted	l,						24	4a. Was an	24b. We	re autor	sy findings a	vailable
ב	o = 0	E							10	autopsy performed* Xes 2 □ I	dea	atb?	ipletion of ca 2□ No	use of
Vital	ysician: Th is certificate director, peg	Bec	25. Was case referred to medical examiner?			Andrew		26. Place	of Death /Che	The Samuel Control		-,		
5	g v =	၉	1X Yes 2 No	ospital:	itient 2 🗆 E	ER/Outpatient	3 DOA Oth	or: 4 □ Nur:	sing Home 5	Residence	6 □Other	(Specify	)	
	ding Ph h. After thi funeral	ë	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of I	jury Jay Yea <i>r)</i>	28b. Time of <b>30</b> ry	28c. Injun Work	at ?	28d. D	escribe how in	jury occurred		unk	
<u> </u>	Attending F ar death. rector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	found		found	a	/es 2 <b>]</b> [N					_	
DIVISION	5 ± = c	ertification;	4 Homicide determined	building,	etc. (Specify,	)	eet, factory, office		Ci	cation (Street ity or Town, St	ite) 13 N	ewhi	irv Ct	18 <i>1</i> ,
_	spital or Atten ours after deat ieral Director: filled in by the	O	20a Carifiar 4 Cariffian Th	1	at ho				Layt	tonsvil	le, Ma	ryla	ınd	
	To the Hospital  within 24 hours a  To the Funeral C  completely filled i	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	er: On the basis and manner	or examinati	viedge, death ion and/or inv	occurred at the tin estigation, in my o	e, date and pinion, death	place, and du n occurred at ti	e to the cause he time, date a	(s) and mann nd place, and	er as sta d due to	ated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier				29c. License	number		29d. [	Pate signed (	Month, L	Day, Year)	
	JU &		To shall	eal :	Un		OCM	E		AUG	JST 20	0, 2	005	
4	Salar	}	30. Name and address of person who col	npleted cause o	f death (Item	23a) (Type, F						_ , _		
	0/12		Tasha Z aveen		1.0		PENN STR	EET, I	BALTIMO	RE, MAI	RYLAND	, 21	201	
	Sta		31. Date filed (Month, Day, Year)	7	strar's Signat	ure	harte							
	Registr		ALIC 9 6 20	INTI S.		K R	20101							

ease Type of Phint in black indelible link. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygien 2015  1 Item 23a per Dr., G846, 08/26/05dbb  Certificate of Death	28040
Certificate of Death Reg No.	

			1 - State Avicence 1 Ces	u 23a per Dr.	Cer	tificate of	Death		Reg. No.		7:
			1. Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
1 1	Physici	_	MILLIP	THE CHARM	N NT			AUG.	20,2	Year 005	10 AM
Y	/Medic	.00	4a. Fecility Name (If not institution, give s	LEE SHERMA	71/	4b. City, Town, o	or Location of Deat			ounty of Deatl	h
le.	Examin	er		_	L411	BALT				NT / 7A	
(500)			5. Social Security Number 6. Sex			If Under 1 Year			rth	N/A 9. Birtl	hplace (State or Foreign
6	Funeral Director			]M 2□F	52 Yrs.	Months Days		. (Month, D	ay, Year)	Co	untry)
1	2		Usual Residence of Decedent		52			JAN.	23,1	903 5	.CAROLINA
	land		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Mary f sh	ō	MD. N/A		חזגם	IMORE					1 ☐ Yes 2 ☐ No
	the !	Director	10e. Street and Number		דוועם	10f. Zip Code			10a Citize	on of What Co	untry?
	Mith De p	늅		male	477		. 7				and y :
	72 hours after death with the Maryland natural; or Itams 23a or 28e-f show dical Examiner must be nuitliad at	Funeral			L411	2120				S.A.	d-sa tadisa
	ar de	nu		12. Was Decedent Ever in U Armed Forces?		Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	0- 14	Black, White	
36	or l	by F	1 Never Married 2 Married	Y Yes 2 No H Yes, Give	1	I □ Yes 2√2 No	Specify:		S	pecify: DT	ACK
21215-0036	uraf	g p	3 Widowed 4 Divorced	Year or Dates:						ית פי	
r.	72 nat	Completed	15. Decedent's Educ (Specify only highest grade	cation e co <i>mpleted)</i>	(Give		during most of wo	rking	16b. Kind	of Business/l	Industry
2	within ene.	Id II	Elementary/Secondary (0-12)	College (1-4or 5+)	IITE. L	DO NOT use retire	ia)				
	Hygiel Hygiel other t		12TH		DISA	BLED	T		NOI		
2	be fill	Be	17. Father's Name (First, Middle, Last)					me (First, Middle		ımame)	
<u>a</u>	should be nd Mental marked o	၉	FRANK SHERMA	N SR.			WILLI	E KING			
Maryland	2 shc and Is ma		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (Street	and Number or R	ural Route Numb	er, City or T	own, State, Z	(ip Code)
	l and line 27 mm 27 her tr		CLYDE L. SHERMAN	N (BROTHER)	250	9 EDMON	IDSON AV	7E. BAL	TIMO	RE,MD	. 21233
altimore,			20a. Method of Disposition			sition (Name of natory or other pla	ce)	Date	20c. Loca	tion - City or	Town, State
Ĕ	permit. Pages Department of t Importent: If It any injury or or once.	-	1 Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		ODLAW	N CEMET	ERV A	ıg. 26,	2005	BALTO	1.1005
Ħ	artm orde inju		21. Signature of Funeral Service		22	. Name and Addre	ess of Facility				1,500,000,000
ä	permi Depar Impor any ir		O D KE	-21		CALVIN	B. SCRU	IGGS FU	NERAL	HOM	3
	· · · · · · · · · · · · · · · · · · ·		23a. Parti: Enter the disease, or compli	cations that caused the deal	th. Do not ente	er the mode of dy	PRESTO	c or respiratory a	BALTO	J, MD	Approximate
40%			shock, or heart failure. List only on Immediate Cause (Final								Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	Metastati		Cancer					6 mos.
	Examiner			Due to (or as a consec	quence of):						
		-	Sequentially list conditions,	Due to (or as a consec	uonoo of\:						
	pe iis	l le	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or,						
	ecut and -tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	augus of):						
20	oe ex			Lata 2	tuerice of).	1.	2100	h			~ (-nas
68760,	that the death certificate be executed net by the attending physician and detached for use as the burial-transit	Medical		16,000	106	C 21	tall C	and	7		10110
9 x	ing p	Mec	IF FEMALE:								
Bô	ith ce tend		23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	у		230	<li>d. Date of delification</li>	very Day Year
0.	ed for u	by Physician	1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of o	death 5	Other (specify)				WORTH	Day 10a.
P.	at the	بر کر	9 □Unknown								
Ś	igned be d	À	Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	iderlying cause gr	ven in Part I.				the cause of death?
Ď	The law requires that the ate has been signed by the bage 2 should be detache	ed						123	Yes 2□1	No 3□Pro	obably 4 Unknown
ပ္ထ	aw re s be 2 sh	Completed						24a. Was		24b. Were au	topsy findings available
æ	The I	Eo							ormed?	death? 1 ☐ Yes	completion of cause of 2√2 No
<u>ra</u>		a	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only		1 1 1 1 1 1 1 1	2,0110
5	Physicien: this certific ral director,	0 8	examiner?	lospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ct	200	dome 50Res		7Other /Spa	nifie)
o	E = E		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju		28d. Describe			
on	ding Phi th. After thi funeral	to	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2 □ No				
S	dea dea ctor y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, stre	et, factory, office		28f. Location (	Street and N	Vumber or Ru	ral Route Number,
Division of Vital Record	after Dire	Certification:	4 Homicide	building, etc. (Special	ly)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			wn, State)		
	spite ours seral filled		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	owledge, death	occurred at the tr	me_date and place	e, and due to the	cause(s) an	nd manner as	stated
	24 h	Medical	(Check only 2 Medicel Examir one)	ner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my	opinion, death occi	urred at the time,	date and pl	ace, and due	to the cause(s)
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date s	signed (Month	n, Day, Year)
	->-0		100 and al	E garner	DO M	D ni.	41-2 =	422	1792	-77	- 2005
			30. Name and address of person who co	empleted cause of death /Iter	n 23a) (Tune	Print)	1033	, 0,		~~	- 2005 nev. Ballino
	10		Alide Areci	Dinos	22 0	Streou	Groon	chairm	Como	ier Cer	Nev. Ballineo
₩.	Sta	te	31. Date filed Month, Day, Kear)	32. Registrar's Signa		V .					MD
		-	HUU Z D ZUUS	Difference OF	40000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20528041 For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUG. 22, Day 2005 Yeer **Physician** ALBERT F. SKALINSKI 5:50 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE TIMONIUM STELLA MARIS HOSPICE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 89 JUNE 14, 1916 212-01-6583 MD. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked othar then "natural", or iteme 23a or 28a-f show other traumatic event. The Medical Examination at the notified at 1 Yes 2 □ No BALTIMORE Director N/A MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 21224 6925 E. BALTIMORE ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: Specify: WHITE þ 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHEM STEEL STEEL WORKER 8TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY UNKNOWN FRANK SKALINSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 203 CRANBURY RD., PRINCETON JUNCTION, N.J. 08550 RICHARD SKALINSKI/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND 4 Donation 5 □ Other (Specify) ST. STANISLAUS CEM. 8/25/05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part1. Enter the diseas of samplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail use. List only ne cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LUNG CANCER Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) 68760 Physician/Medical use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 ☐ Yes 2**X** No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending P s after death. Il Director: After 1 Natural 5 Pending Injury To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 TYes 2 TNo 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 43725 J, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIO MAHMOOD 31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar DHMH 17 Rev 1/2001

UGUST 22, 2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28042 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** TOLAN MELYN /Medical 08-12-2005 06:00p4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth Fox-Chase Nursing & Rehab Silver Spring Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F 86 Months Days Director 445-01-7867 09-09-1918 Arkansas Usuel Residence of Decedent Pagas 1 end 2 should be filed within 72 hours after death with the Manyland ment of Haaith and Mentel Hygiana.

ant: If Item 27 is marked other than "natural", or itema 23a or 28a-f ahow ury or other traumatic event, the Madical Examinar must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 513 N. Horners Lane Completed by Funeral 20850 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 3+ US Navy Military/Defense 17. Fether's Neme (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Ambrose Martin Mears Caroline Elizabeth Sorrels 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol S. Tolan/daughter 112 Littleton Circle Delano FL 32724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Department of H Important: If its any Injury or ot once. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Chesapeake Crematory 08-24-2005 Beltsville MD 21. Signature of Funeral Service Licens 22. Name and Address of Fecility M00382 Rapp Funeral & Cremation Service 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) LIVER DISEASE Examiner Examine burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest physician s the burial Physician/Medical Due to (or es e consequence of): attanding pl signed by the a of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ certificate has been si irector, paga 2 should Completed 24b. Were autopsy findings available prior to 24a. Was en autopsy completion of cause of deeth? 1 ☐ Yes 2FTNo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? funaral director. Certification: To Be 26. Plece of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No this 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division ours after deen.

I Director; An.

In by the fur-5 Pending investigation Naturel 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Complataly filled Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) MD

State

0

SHA

31. Date filed (Month, Day, Year)

AUG 2 6 2005

Registrar DHMH 16 Rev 6/95

860

32. Registrar's Signature

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

GULLA

DO06109

SECONDAVENUE SILVER SPRING

Director

filed within 72 hours after death with the Maryland or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heath and Mental Hygiene. and the Hattle and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-4 show ary or other traumatic event, Ite Madical Examinatment to notified at permit. Page Department o Important: If any Injury or once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

death certificate be executed burial-tran the attending physician use as the detached The law requires that the s been signed by the should be detach page 2 this certificate or Attending Physician: the funeral After death. after death filled in by within 24 hours a To the Funeral I

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygien 0 0 5 28043 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day James Albert Thompson 08 23 2005 05:30a<sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2661 Cory Terrace Wheaton Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 3 M 2 □ F 72 Months 578-40-9248 01-16-1933 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD 1 N Yes 2 No Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2661 Cory Terrace 20902 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Salesman Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Edward Thompson Laura Mobley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24270 N. Patuxent Beach Rd. California MD 20619 Cindy Farbizio/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 08-25-2005 Beltsville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Me0382 Attle & Dhumann Rapp Funeral & Cremation Services 933 Gist Ave Silver Spring MD 20910 23a. Part1. En in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infraction Due to (or as a consequence of): Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Coronary Artery Disease Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Seizure Disorder 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 🗆 No 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 🗌 Inpatient Other: 4 Nursing Home 5 🛣 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0058962 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shashank G. Patel 15020 Shady Grove Rd #300 Rockville MD 20850 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Specker Registrar AUG 2 6 2000

DHMH 17 Rev 1/2001

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of H tificate of I	lealth and N Death		ien <b>2</b> () (	15	28044
I	Physici /Medic		1. Decedent's Name (First, Middle Jeanne Mari						2. Date of Deat Month August	Day	Year 105	3. Time of Death 6:45a
	Examin		4a. Facility Name (If not institution Continuum Care				4b. City, Town, or Sykesvi	r Location of Death		4c. County Carr		
	Funeral Director		5. Social Security Number 212-90-4539	6. Sex 1 ☐ M 2 ☐ 7 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 17	Year)	9. Birthp Cour Md	place (State or Foreign ntry)
	Maryland -f show fled at	tor	Usual Residence of Decedent  10a. State 10b. County  Md York	,		City, Town or Lo					1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28a	al Director	10e. Street and Number 4828 Glenvil	le Road			10f. Zip Code 17327	7	10	0g. Citizen of W	/hat Cour	ntry?
136	irs after dea il', or items	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☐ Widowed 4 ▓ □ Divorced	ried 1 Tyes	2 No ive X		Was Decedent of H f Yes, specify Cuba I ☐ Yes 21 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Blac	- Americ k, White, whit	
215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Mcdical Examiner must be motified at	Completed I	15. Deceder	nt's Education est grade completed		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work f)	king	16b. Kind of Bu	siness/In	
land 2	be do do	To Be Cor	17. Father's Name (First, Middle, Paul Joseph W	,	r.	den	tal hygie	18. Mother's Nam	e Agnes S		<u> </u>	
, Maryland	2 shou and N Is mar	-	19a. Informant's Name/Relations Mr. & Mrs. Pau	ship <i>(Type, Print)</i> ( 1 William	parents	) 19b. Mailir 4828	g Address (Street a	and Number or Rui	ral Route Number,	City or Town,		Code)
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to 2002.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (5			Place of Dispo cemetery, crem ringfie	sition (Name of natory or other place 1d Cemete	ery 8-27	Date 2 -05 S	ykesvi1	City or To	Md
Ball	permit. Depart Import any inj		21. Signature of Funeral Service  Page Haigh		*	22 P	.0. Box 1	<sup>ss of Facility</sup> Ha 195 Sykes	ight Fun ville, M	eral Ho d 21784	me &	Chape1
	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	caused the dealer line.	elait	er the mode of dying	9205	2,2			Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	p. 13	(or as a conse	1207	nest 7	Desch	61018	ncy		
8/60,~	icate be executed physician and s the burial-transit	edicai Examin	that initiated events resulting in death) Last	c	(or as a conse	quence of):						
O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	1 Live	utcome of pregr birth 2 Tet nant at time of nown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ery Day Year
rds, P.	The law requires that the te has been signed by the has been signed by the hage 2 should be detache	by	Part II. Other significant conditi	X )	eath but not re		nderlying cause give					ne cause of death?
Hecords,		Completed							24a. Was ar autopsy perform 1 \( \text{Yes} \) 2	ned? d	/ere auto rior to cor eath?	psy findings available mpletion of cause of 2 No
or Vital	و ا	To Be	25. Was case reterred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	]ER/Outpatien	t 3 DOA Othe	or /	h (Check only one		r (Specify	y)
DIVISION C	To the Hospital or Attending Pl within 24 hours after death. To the Suneral Director: After th completely filled in by the funera	Certification:	27. Manner of Death  1 Natural 5 Pendii 2 Accident investi 3 Suicide 6 Could	igation not be	of Injury oth, Day Year)	28b. Time of Injury		vat k? Yes 2 □No	28d. Describe ho			
2	pital or Al		4  Homicide determ	build	ling, etc. (Spec	sify)	eet, factory, office		28f. Location (Str. City or Town,	. State)		
	the Hos thin 24 ho the Fun empletely	Medical	(Check only one)  2 Medicel  29b. Signature and title of certifie		pasis of examin	nation and/or inv	restigation, in my op	oinion, death occur	red at the time, da	use(s) and man te and place, a d. Date signed	nd due to	the cause(s)
	_		30. Name and address of person	3 Kenon	My see of death (to	230\ (T)	MIL	1753	23	8/52	101	)
	<i>I</i> 5	to.	31. Date filed (Month, Day, Year,	COURT	- KO	P	KESVILL	E, MI	) (	21133		
	Registr		AUG 2		Lasters .	H. A	and a					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DOMINIC (MMN) TACCHETTI 08 25 2005 9:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARINER HEALTH FOREST HILL HARFORD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2 □ F 1926 Maryland Director 79 220-12-2883 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be neitilized at 1 ☐ Yes 2X No Director Maryland Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2038 Knotty Pine Drive 21009 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Examinations." 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Assire DO NOT us retired to Chief of
ESRS, Social Security Admin. 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Victor (NMN) Tacchetti (MMN) Papiri Anna 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2038 Knotty Pine Drive, Abingdon, Maryland 21009 Rick Tacchetti / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation / 5 ☐ Other (Specify) Towson, Maryland Hilltop Service Corp. 8-26-05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. ung 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** METHSTATIC colon concer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed' 1 ☐ Yes 'X ☐ No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 5 Pending Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Daw 5 D32522 August 25, 2005 J. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN, 615 W. MACPHAIL ROAD, BEL AIR, MD 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) AUG 2 6 2005 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TROTT Month Yeer 7:00 8 M Physician DOROTHY H. 1200 ugust /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Halth Dernie re. 11 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 XF -22-1512 June 11 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Anne ArundeL e Director 10g. Citizen of What Country? 10e. Street and Number WBNA 7 608 21060 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 0 1□Yes 2010 Baltimore, Maryland 21215-0036 Specify: Specify: Q1 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ustodian Baltimore City 19th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be the page of Health and Mental I is not if item 27 is marked of Smalls Sea trice 2 0191 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relation hip (Type, Print) - husbard ma. - Trott 7608 WBNA ad. Glen onald 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State en Haven mem. PK ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funetal Service Licensee 22. Name and Address of Eacility, Genglimarch Runera Saeto nd 12/22 Fifter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ROSEPSIS WKS. **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** INFECTION RACT INARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Box 68760. by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year been signed by the atte should be detached for 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed Stec Door 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 △ No has autopsy perform certificate Merematord 1 Yes 2 X No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Division 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signal and title of certifier ELL durel Hending DASE 8/23/2005 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITH CHANDELWAL MD., 1600 S. Co GLEN BURNE, Md, S. CRAIN HWY # 610 V 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere O.O.F.

		•	For State Registrar	State of Marylan	Certifica	nt of Health and te of Death	Reg.	6000	28047
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	" Tale			2. Date of Death Month Augil 31	Day 3 2002	3. Time of Death
	Examin		4a. Facility Name (If not institution, give	street and number)	Hal Ba	Town, or Location of Dea		4c. County of Deatl	1/4
	Funeral Director		5. Social Security Number 6. Social Security Number 115-24-6759		7 Yrs. If Undo	er 1 Year If Under 24 Hr. B Days Hours Mir		ear) 9. Birth 1928 M	hplace (State or Foreign untry)  any land
	nyland how		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location	- /	/		10d. Inside City Limits
	r 28a-f s	irector	10e. Street and Number	7/-	10f. z	Utmou ip Code	2	. Citizen of What Co	1 Yes 2 No untry?
	seath with mit as 23 a o	eral D	1722 6	12. Was Decedent Ever in U.	Ave I3. Was Dec	2/2/) edent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ame	ncan Indian.
9036	ours after o	d by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		ecify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show important: If item 27 is marked other than "natural", or Items 23e or 28e-f show apply injury or other traumatic avant, it. Medical Exam. In must be notified at anone.	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT	ual Occupation york done during most of we use retired)	orking 161	b. Kind of Business/I Leen de	amats
	buld be filed with Mental Hygiene arked othar thai atic evant, the	To Be Co	17. Father's Name (First, Middle, Last)	as Tato	Lacro	18. Mother's Na	me (First, Middle, Mai	iden Sumame)	d
Maryland	12 should h and Men 7 Is marke fraumatic	ř	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addres	ss (Street and Number or F	3 4	10	Tip Code)
	Pages 1 and 3 nent of Health ant: If itam 27 ury or other tru		20a. Method of Disposition	20b. P Removal from State	Place of Disposition (Na cemetery, crematory or	other place)		c. Location - City or	Town, State
Baltimore,	permit. Page Department ( Important: If any injury or once.		4 □Donation 3 □ Other (Specify 21. Signature of Funeral Service) Con		rinity C	and Address of Facility 270 Fred	ilten Pass	> o	ere ing.
	40240		23a. Part Lenter the disease, or compshock, or heart failure. List only	dications that caused the death	h. Do not enter the mo		neral Hone	- Dalto.	Approximate Interval Between
ľ	Physician /Medical		Immédiate Cause (Final diséase or condition resulting in death)	a. Preumon  Que to (or as a consequence)					Onset and Death
ŀ	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Stroke Due to (or as a consequence)	uence of):				
	rificate be executed g physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):				
68760,	physicia physicia s the bur	edicai	(	d					
.O. Box (	The law requires that the death certil to has been signed by the attending rage 2 should be detached for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	I death 3 Ectopic:		···	23d. Date of deli Month	ivery Day Year
s, p	uires that t signed by lid be deta		Part II. Other significant conditions o	ontributing to death but not resi	ulting in the underlying	cause given in Part I.		cco use contribute to	
Vital Record	rhe law requira te has been si age 2 should I	Completed					24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
Vital	Physician: The law this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Cther	1 Ves 2 death (Check only one)		
	<u> −                                   </u>	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	Home 5 Residence 28d. Describe how		eify)
Division of	or Atten ifter dea Diractor in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, facto		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	e Hospital 24 hours a a Funaral C	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occ	ee, and due to the caus curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
,	To the within 2 To the complet	Me	29b. Signature and title of certifier	R		9c. License number		Date signed (Month	n, Day, Year)
	7		30. Name and address of person who	empleted cause of death (Item	n 23a) (Type, Print)	54548 Typnd Ges	neenO k	1050 to	- · L
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature Sparker	June City	Topics /	v -period	

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 28049 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Yeer Richard 840 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. mer! 5. Social Security Number 6. rentist CONTR 8. Date of Birth (Month, Day, Year) Birth place (State or Poreign Country) 6. Sex 7. Age (In yrs. last birthday) Funera! Days 10M 20F Hours Min Yrs. Director 330-32-1769 April 22 A39 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23e or 28a-f show other treumstic event. The Micdical Examiner must be notified at 1 Tes 2 No Be Completed by Funeral Director Burtonsully 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20866 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Days 2 No Navy 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1958-1960 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H фq ၉ Sidnes wner 19a. Informant's Na Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Item 27 20b. Place of Disposition (Name of Dr. Butersulle, MD 20864 20a. Method of Disposition Date 20c. Location - City or Town, State † <u>-</u> cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 8-29-01 ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility AM lasa Middley Jesse Dr. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or re-piratory arrest, shock, of brant failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease in condition **Physician** Due to (or as a unsequence of): /Medical resulting in death) Examiner ardiae Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and on the cause of the caus Examiner Due to (or as a consequence of) death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No detached 9□ Unknown 9 Unknown The law requires that the certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1 ☐ Yes or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No 1 thipatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) vd ni bellil 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 8han 200) 16073 M 30. Name and address of person who completed the of death (Item 23a) (Type, Print) 204112 Shame 7600 Kathleen 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygienes of

			1 - For State Registrar	Otato of ma	.y.a.i.a.i	Certificate of	Death		g. No.	28050
			Decedent's Name (First, Middle, La.	st)				2. Date of Death	1	3. Time of Death
	Physici /Medio		Frances M	. Veni	cK			AUGUST	24, 2005	1:00 A M
).	Examin		4a. Facility Name (If not institution, give	e street and number)		,	or Location of Death		4c. County of Dea	
			RUXTON PIKESVII				SVILLE		BALTIMO	
	Funeral Director		212 20 3031	Sex 7. Age	(In yrs. last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG.21,	1924 9. Bir	thplace (State or Foreign ountry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Manyl f sho	ō	MD N//	Δ	P	ALTIMORE				1 V Yes 2 □ No
	1 the	rec	10e. Street and Number	•		10f. Zip Code		10	g. Citizen of What C	ountry?
	h with	Funeral Director	6317 PARK HEIGH	HTS AVENUE	#T-4		21215			USA
	ems deat	ner	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H	Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Am Black, Whi	
5-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 show the Marical Exercites marke notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 Ø N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 💢 No			Specify:	WHITE
2	72 h	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of worki	ing 1	6b. Kind of Business	/Industry
7	within and the shape of the sha	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	lite. DO NOT use retire IWNER	d)		MARKET RE	CENDON
р О	Hygie ther	ပိ	17. Father's Name (First, Middle, Last)			MINEIX	18. Mother's Name			SLANGII
Maryland 2121	id be ental ked o	To Be	BENJAMIN		FRIF	DLANDER	RUTH			RIEDLANDER
ar Z	should nd Men marke umatic	-	19a. Informant's Name/Relationship (	Type, Print)		Mailing Address (Street	1	al Route Number,		
	1 and 2 Health a em 27 la		SUE VENICK / DA	AUGHTER	63	17 PARK HEI	GHTS AVEN	UE #T-4	BALTIMO	RE, MD 21215
ore,	of He of He fitern r othe		20a. Method of Disposition 1 🗡 Burial 2 □ Cremation 3 □	Demouslife State	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ce)	Date 2	Oc. Location - City or	Town, Stete
Ĕ	Pages ment of l ant; If its ury or o		*4 □ Denation 5 □ Other (Specif		ADATH	YESHURUN CE	M. 08/25	/2005	BALTIMORE	, MD
Baltimore,	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event. In an once.		21. Signature of Fureral Service Line	56e		22. Name and Addre	ss of Facility SO	L LEVINS	ON & BROS	., INC.
_	205 3 3	1	MUNUAL	WAT	>					, MD 21208
			23a Fart1. Enter the disease, of com shock, or heart failure. List only	one cose on each lin	a. 1					Approximate Interval Between Opset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Cere	boul vas	cular	Clesia	u	Unlum
SE	Examiner			Due to (or as a	consequence o	f):				
		e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence o	of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequence o	of):				
68760,	rtificate be executed ng physicien and s as the burial-transit	Medical	•	d						
			IF FEMALE:							
Вох	The law requires that the death cer nite has been signed by the attendir bage 2 should be detached for use	Physiclan/	23b. Was decedent pregnant in the past 12 mooths?	23c. If yes, outcome of	Fetal death	3 Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	ime of death	5 ☐ Other (specify) _				,
	that the ed by detac	/Ph	Part II. Dther significant conditions of	ontributing to death bu	t not resulting in	the underlying cause give	ven in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
gp	uires sign Id be	d by	lul	unson.	2			1 ☐ Ye	s 2 € No 3 □ P	robably 4 Unknown
S	w req	Completed	New	1000 ation				24a. Was an	24b. Were a	utonsy findings available
Re	fhe la te has age 2	mo						autopsy	ed? death?	utopsy findings available completion of cause of
ta	an: Tifica tor, p	0	25. Was case referred to medical				26. Place of Death	1 Yes 2		s 2 No
<u> </u>	ysici	To B	examiner? 1 \( Yes \) 2 \( \sum \) No	Hospital: 1 ☐ Inpatier	t 2 ER/Out	patient 3 DOA Oth	ner		nce 6 Other (Spe	ecity)
0	Attending Physician: or death. ector: After this certification in the funeral director, it		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. T	ime of 28c. Injury Wo	ry at rk?	28d. Describe how	w injury occurred	
Sio	eath. or: A	catle	2 Accident investigation	n			Yes 2 □No			
Division of Vital Records,	or Att	ertification:	3 Suicide 6 Could not b		ry - At home, far (Specify)	m, street, factory, office		28f. Location (Str. City or Town,	eet and Number or A State)	lural Route Number,
	pitel ours a erel (	O	29a. Certifier 1 Certifying Ph	version: To the hest o	I mu knowlodes	dooth convert of the ti-	dot- and slave			
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Exar	niner: On the basis of and manner stat	examination and	, death occurred at the tide of the distribution of the distributi	ppinion, death occurr	ed at the time, da	te and place, and du	e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Mon	th, Day, Year)
)	/		) H	7 WI	)	i	1)27569		81241	105
	'n		30. Name and address of person who	completed cause of de		Type, Print)			81241 Rl	
	J		Men	Jettem	m	1838 GI	cene '	1 acc	141	21208
	Sta	_	31. Date filed (Month, Day, Year)	32. Pojistra	r's Signatur	Discours				
	Registr	af	AUG 2 6							

DHMH 17 Rev 1/2001

1:10 AM

8-24-05

UNKNOWN 05-05498 TZG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a, 27, 28a-tmperME, 6846, 8-29-05 TT State of Maryland / Department of Health and Mental Hygiene O O E

S. VONHENDE	State Registrar	,	Certificate of De	eath	Reg. No.	28051
	1. Decedent's Name (First, N		2 .	2. Date of D		3. Time of Death
Physiciar /Medica	Karı	in S. Von H	endricks	AUGUS		1512 P <sup>M</sup>
Examine	4. 5 10. 11. 11. 11	ution, give street and number)	4b. City, Town, or Lo	cation of Death	4c. County of Death	1
	2845 W. LAFA		BALTIMOF		NIA	
Funeral Director	5. Social Security Number 217-66-805	1 12W 20F 3		Under 24 Hrs. 8. Date of Bi Month, D Jan, 13		nplace (State or Foreign untry) aryland
	Usuel Residence of Deceden		City, Town or Location			10d. Inside City Limits
be notified a	10e, Street and Number	NA	Date	temare		1X1Yes 2□No
Items 23a or 28a-f show	3009	Guynn Fal	Lo PKery 21	216	10g. Citizen of What Cou	intry?
	3 □ Widowed 4 □ Divo	If Yas Giva	If Yes, specify Cuban, I	anic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.) Specify:	14. Race - Amer Black, White Specify:	ican Indian, setc.
event, it e Medical Exercity	15. Dece (Specify only hi	dent's Education ghest grade completed)	16a. Decedent's Usual Occupatio (Give kind of work done duri life. DO NOT use retired)	n ng most of working	16b. Kind of Business/li	ndustry
8	Elementary/Secondary (0-	(2) Callege (1-4or 5+)	Tractor Trai	for Driver	2 0915	stics the
9	17. Father's Name (First, Mid			. Mother's Name (First, Middle	a, Maiden Sumame)	
To e		one La	gan 1	Debarah	Von Hen	dricks
	19a. Informant's Name/Relat		19b. Mailing Address (Street and	Number or Rural Route Numb		
other traumatic	Deborah Von	Hendincks-mott	ner 3009 Grussonst	alls PKwy. B		/
	20a. Method of Disposition	20	b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or T	
5	1 Surial 2 Cremat	OU 2 THOUGH AND IN STATE	Cornetory, cromatory or other piace)	C 8-29-05	Butterno	1 md
eny injury o	21. Signature of uneral Sen		22. Name and Address of	of Facility.		2,.101
eny i	1		1 270	Fred HILTON F	455	10,000
	23a Part1 Filler the diseas	e complications that caused the d	eath. Do not enter the node of dying, s	ich termenal the	ne palto is	
	snoot a neart failure.	List only one cause on each line.	eath. Do not enter the mode of dying, s	den as cardiac or respiratory a	irrest,	Approximate Interval Between Onset and Death
cian	Immediate Cause (Final disease or condition	_a Cocaine In	toxication			Orisot and Death
ical ner	resulting in death)	Due to (or as a con	sequence of):			
•	Sequentially list conditions	b				
Tar-transit	Sequentially list conditions, any leading immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	neignende of):			
8	Cause (Disease or injury that initiated events	С.				
ů	resulting in death) Last	Due to (or as a con	sequence of):			
Modical		d.				
as a		1				
hy Physician/Medical Evamin		23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3 ☐ Ectopic pregnancy		23d. Date of deliv Month	rery Day Year
Ó	Part II. Other significant con	ditions contributing to death but not	resulting in the underlying cause given in	n Part I. 23e. Did	tobacco use contribute to I	the cause of death?
1		•	, , , , , , , , , , , , , , , , , , , ,		4	bably 4 🗆 Unknown
Completed						
1 2				24a. Was	prior to co	opsy findings available empletion of cause of
2	3			12X Yes	ormed? death? 2 ☐ No 1 🗷 Yes	2 □ No
o c			26	. Place of Death Check only	one)	
ß	1 ☐XYes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	PER/Outpatient 3 □ DOA Other:	4 ☐ Nursing Home 5 ☐ Res	idence 6 Dother (Speci	ty) SCENE
(G		28a. Date of Injury (Month, Day Year	28b. Time of 28c. Injury at Work?	28d. Describe	how injury occurred	
2 4	2 Accident inv	estigation Pnd 8-14-05	rnd 1 Yes	XX No		unk
ed in by the funeral	3 ☐ Suicide 6 😿 Co		t home, farm, street, factory, office ecify)	28f. Location (	Street and Number or Run	
è	5	FOund in h	ouse			Lafayette
		ffying Physician. To the best of my	Kilowiedge, death occurred at the time	date and place, and due to the	cause(s) and manner as s	stated
Inpletely III	(Check only 2 Med	cal Examiner: On the basis of exam and manner stated.	ination and/or investigation, in my opinio	on, death occurred at the time,	date and place, and due t	o the cause(s)
completely filled in by the funer	29b. Signature and title of ce	tifier	29c. License nu	ımber	29d. Date signed (Month,	Day, Year)
0	Last	14.01	(A) OCME		ATTOTION 1 F	2005
	20 Name and additions	y see p	OCME OCME		AUGUST 15,	2005
	Company & to a de	son who completed cause of death (	111 DENN CTD	EET, BALTIMORI	T MADVI AM	21201
0.	04 0 4 17 4 14 14 15 14 14	enberg M.D.		TOT, DALLINGKI	, THAK LLIAND	21201
State Registrar	1	1 66	J. April			
- Gistial	AUG 2	YUUJ JUNE	-1			

State of Maryland / Department of Health and Mental Hygiene 2005 28052 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Judith Jean von Oppenfeld August 19, 2005 1808 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F 89 Director 29, 1915 079-12-7820 Nov. New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be retified at 1 ☐ Yes 2 ☑ No Maryland Montgomery Chevy Chase Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8100 Connecticut Avenue, Apt. 1622 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ₺ No Specify: þ 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Homemaker Own Home marked othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be Rodney Gilbert Pownall Emma Mathilde Rathke and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20815 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an Horst von Oppenfeld/Husband 8100 Connecticut Ave., Apt. 1622, Chevy Chase, MD. Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium, Inc. August 21, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department important: If important: If any Injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 Service Licensee 3Bins 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardigalmonary /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) 68760, Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 2 🗌 No 1 Yes Vital After this certific funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Hapatient No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA ate of Injury (Month, Day Year) Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division within 24 hours after death.

To the Funerel Director: After completely filled in 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 C Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8/19/05 MD 6388791 newsmarkwell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mellise Means-Markwell, M.D., 8100 Old Georgetown Road, Bethesda, Maryland 20714 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 2005 16 1000 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician williams Kenee 9:10 PM 08.24. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MILLENIUM NURSING CTR. ELLICOTT CITY HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 1 F 218.44.6828 Yrs Director 05.15.1949 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Ita Mudical Examinar must be notified at 1 ☐ Yes 2 XNo Director MD MARRIOTTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? FREDERICK ROAD 11320 OLD 21104 death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite any injury or other traumatic event. Its Medical Experimen 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: BLACK Specify þ 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)

Z YRS Elementary/Secondary (0-12) LPN CIR. FOR LEARNING 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT A. WILLIAMS GLADYS F. NORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE DECK (DAUGHTER) 11320 OLD FREDERICK RD., MARRIOTISVILLE, MO 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT 08.26.05 BALTO . MO 21. Signature of Funeral Service Licens 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVCE Vaugh 5151 BALTO. NATI PIKE, BALTO. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebro Vascular Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. East of control of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 至 Ûnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 **X**(No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: 1 ☐ Yes 8 Z No 2 ER/Outpatient 3 DOA 4€ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Matural 5 Pending 2 □No investigation 1 Tyes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back River Neck Road (ARIC) 1AHMOUD 31. Date filed (Manua) \$2. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28054 For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 8:20 PM AUGUST 2005 ERMA L. WEST /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA ST. MGNES HEALTH CARE BALTIMORE, MD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1 □ M 2 X F Months Davs 212.22.5630 Yrs. mo Director 10.30.1926 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b County or 28e-f show the Medical Examiner must be notified at 1 XYes 2 No NA Completed by Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 135 GRANTLEY STREET 21229 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 ō Specify: BLACK 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NURSING HOME NURSES AID NA 8114 GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Pages 1 and 2 should be fill ment of Health and Mental H sant: If itam 27 is marked other. MARIE QUEENI THOMAS RYAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HUSBAND) 735 GRANTLEY ST. BALTO. MO ARTHUR H. WEST other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. ARBUTUS BALTIMORE 08-24-05 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAYS. Frysician ISCHEMIC SMALL BOWEL. /Medical Due to (or as a consequence of): Examiner MONTHS CONGESTIVE HEART Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPOTHYROIDISM 1 Yes 2 No 3 Probably 4 Onknown DM 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 2 No GOUT. 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Japiter 4 hours after dea..
-rel Diractor: Afr 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospitel o within 24 hours aff To tha Funarel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 29c. License number P-17610 AUGUST 18, 2005 MURIANA KAZMI, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAMU, MD. BALTIMORE, MD 21229 HOSPITAL. 900 S. CATON AVE, MURTAM ST. AGNES 31. Date filed (Month, Day, Year) AUG 2 6 2005 32. Registrar's Signature State forks Registrar

Amend Items: 11 & Islate of Maryland Department of Health and Mental Hygiene 105 28055 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2005 Aug. 23, 1:15p Hazel Waters /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Halthorpe 2816 Louisiana Ave. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 M 2 1 F Maryland 30. 1941 Director 217-38-6937 64 an. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show r than "natural", or Itams 23a or 28a-f shov the Medical Examinar must be nutified at 1 ☐ Yes 12 12 No MD Baltimore Halthorpe Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 USA 2816 Louisiana Ave. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes ★★★ No If Yes, Give Year or Dates: \* Married Married Baltimore, Maryland 21215-0036 1 Yes ¾ No Specify: white Specify: white δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 9th Home Department of Health and Mental Hyg important: If item 27 is marked other any injury or other traumatic event, it once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hazel Booker Stuart F. Sheffield 19a. Informant's Name/Relationship Goorge H. Water Stab. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart F. Sheffield- Husband 2816 Louisiana Ave. Halthorpe, Maryland 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

1. Signature: Funeral Service Leensee Loudon Park Cemetery Aug. 27, 05 Baltimore City 22. Name and Address of Facility Loudon Park Funeral Home permit. 21. Signature 3620 Wilkens Ave. Baltimore, Maryland 21229 lam 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) obstructure July Disease Physician hrone /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed purial-trar Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) 4☐Pregnant at time of death o detached 9 Unknown þ Division of Vital Records, P. should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1□ Yes 2□No 25. Was case referred to medical 26. Place of Death Check only one Be Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 1 ☐ Yes 2 ☐ No 2 ER/Outpatient Certification: To funeral dir this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending To the moor after death.

within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and under to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D23624 Aug 24, 2005 delet 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kandelwal 1600 South Crain Hwy. Glen Burnie, Maryland 21061 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State AUG 2 6 2005 Registrar

			For State Registrar	State of Maryland	Department of H Certificate of L	ealth and M Death	ental Hygier	ne 2005	28056
Ì		100	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia		Raulasl	(1)	in bit		Month D	Day Year	11 38 AM
	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)	4b. City, Town, or	Location of Death		4c. County of Death	
	Examin	eı	Heritage (	2 = +01	1	adalk		Ral	to
ut."	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		212-26-1855 10M	201 80	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	925	ntry) MD
			Usual Residence of Decedent				OUP! /	100	
	ylan		10a. State 10b. County № №	10c. City, T	own or Location				10d. Inside City Limits
	Mar Mar	Director	WD		Baltin	ore			1 ☐ Yes 2 ☐ No
	r 28	ire	10e. Street and Number	<u> </u>	10f. Zip Code		10g. 0	Citizen of What Cou	ntry?
	h wit	a D	516 Tolna St		a	1224		USA	
	ours after death with the Marylan rel' or Items 23s or 28s-f show Examinar must be multified at	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri Black, White,	
)	after or Ite	F	1 Never Married 2 Married	1 Yes 2 No	1 Yes 2 No	Specify:	nican, etc.)		etc.
3	ours	t by	3 ☑Widowed 4 □ Divorced	Year or Dates:	10 103 219110	Зреспу.		Specify:	White
5	72 hours "naturel",	Completed	15. Decedent's Educat (Specify only highest grade of	ion 1	6a. Decedent's Usual Occupa (Give kind of work done of	ition Jurina most of worki	na 16b.	. Kind of Business/In	dustry
1	thin e.e.	pple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	)	9		
7	od wi	Con	(0		Home	HOSPICU	2	NUYSI	ng
2	at Hy	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	den Sumame)	
2	should be filed within 72 hours after death with the Maryland nod Mental Hygiene. Indexted other then "naturel", or items 23s or 28s-f show imarked other then "naturel" or items 23s or 28s-f show imetic event, it a Modical Examinal must be notified at	္	Herbert E	oavah		Isab4	elle s	· 1/16	rcer
3	2 sho and is m		19a. Informant's Name/Relationship (Type	Print)	19b. Mailing Address (Street a	and Number or Rura	I Route Number, Cit	ty or Town, State, Zip	code)
2	s I and 2 should be filed within 72 hr f Health and Mental Hygiene. Item ZI is marked other then "natur other treumetic event, Ite Mazical		John Ebaugh	Sr. 5	7839 Charl	es Mour	+ Rd. (	30/10/10	D 31995
5	of He roth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	come	e of Disposition (Name of etery, crematory or other place		oate 20c.	. Location - City or To	own, State
	Pages nent of I ant: If it		'4 □Donation 5 □ Other (Specify)		etro Cromato	ry 8-2	9-05 13	Balto, V	MD
2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Importent: If item 27 its marked other then eny injury or other treumetic event, Item once.	İ	21. Signature of Funeral Service Licensee	7//	22. Name and Addres				
ם	80 E 2 8		1 ( Server )	hand	IIAM 123	2 Might	illey Dr	JOSSUP	PA 18434
			23a. Part 1. Enter the disease, or complica shock, or beart failure. List only one	tions that caused the death. [	Do not enter the mode of dying	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease of condition	RONARY	ARTERY	010	EARF	5	Onset and Death
	/Medical		resulting in death)	Due to (or ac a consequen	ice of):	1 0	1100		) / 1/15
	Examiner		Sequentially list conditions h.	下ファロン	LTIALLE	ty PEI	ETEN	SION	184 EARS
	•	Jer	if any leading to immediate	Due to (or as a consequen	ice of):	( '			
	cuted nd ransii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
ŝ	an ar rial-ti	EX	resulting in death) Last	Due to (or as a consequen	ce of):				
2	cate be executed physician and s the burial-transit	dicai	d.						
5	tifica ng ph as th	Ψ							
5	he death certifics the attending ph ched for use as t	N/U	230. Was decedent pregnant	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de				23d. Date of deliv	,
2	deat e att	ici	in the past 12 months? 1 ☐ Yes 2 TNo	4 Pregnant at time of death				Month	Day Year
	res that the de signed by the a be detached f	Physician/M	9 🗆 Unknown	9 Onknown					
2,	s tha	ру Р	Part II. Other significant conditions contri	buting to death but not resulting	ng in the underlying cause give	n in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
ž	w require been sig should b						1 🗌 Yes	2 No 3 □ Proi	bably 4 □Unknown
3	s bee	Completed					24a. Was an	24b. Were auto	opsy findings available
ב	he ta	mo					autopsy performed	death?	ompletion of cause of 2□ No
9	sicien: The law certificate has E lirector, page 2 s		25. Was case referred to medical			26 Place of Death	1 Yes 2 1	No I TUYES	20 140
>	ding Physicien: The Ih. After this certificate ha funeral director, page	To Be	examiner?	pital: 1 Inpatient 2 ER	/Outpatient 3□ DOA Othe		me 5 Residence	6 Other (Special	fv)
5	I Phy ar this aral c		27. Manper of Death		b. Time of 28c. Injury		28d. Describe how in		<i>"</i>
5	th. : Afte	iţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		res 2 □ No			
2	Attender death	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home	a, farm, street, factory, office		28f. Location (Street		al Route Number,
5	after Dire	Certification:	4 Homicide	building, etc. (Specify)			City or Town, St	ate)	
	To the Hospitel or Attending Physicien: The law requires that the death centif within 24 hours alter death.  within 24 hours alter death.  to the Funeurs alter death.  completely filled in by the funeral director, page 2 should be detached for use as	alc		ian: To the best of my knowle					
	e Ho 124 t	edical	(Check only 2 Medical Examine one)	<ul> <li>On the basis of examination and manner stated.</li> </ul>	and/or investigation, in my op	inion, death occurre	ed at the time, date a	and place, and due t	o the cause(s)
	To the To the Somp	Me	29b. Signature and title of certified	X.	29c. License	number	29d. [	Date signed (Month,	Day, Year)
			Harpon	M.D	$\Delta$	4160	1416	V2122	,2000
	2		3d Anna and address of terson who do in	pletedrea st of beath (hem 23	Ba) Tybe. Plin - A	RITCH	TIE HO	SHINIA	43
			MAKALL	BALTI	MORESM	ARYLA	NID 21	1225	(/
	Sta	ite	31. Date filed (Month, Day, Year)	3 Registrar's Signature	(Special)	(-1)			
	Registr		ALIC 2 6 2005	Elemen Ja	. 1				

1 - For State Registrar	State of Maryland / Dep	artment of Health and Mentartificate of Death	al Hygien 2005 28057
1. Decedent's Name (First, Middle, La.  Physician  Age	(1)	M	ate of Death onth Day Year 6.10 p.m.
Medical Examiner  4a. Facility Name (If not institution, give Joseph Richie)	street and number) HUSDICE	4b. City, Town, or Location of Death  Balanons	4c. County of Death
Director 2/4 98 //3/14	ex	Months Days Hours Min. (M	ste of Birth   9. Birthplace (State or Foreign Country)
Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Li Bartin		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the Main the Mai	1	101. Zip Code 2/23	10g. Citizen of What Country?
11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Me	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☐ No Specify:	es or No- 14. Race - American Indian,
Complete than 1, 12 12 12 12 12 12 12 12 12 12 12 12 12	de completed) (Give life.	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
	,	18. Mother's Name (First Alberta	Wastil  Middle, Maiden Sumame)  Libet
Maryland Maryland Agricult 2 Stoud 2 S	Type, Print) 19b. Mail	ng Address (Street and Number or Rural Rous	te Number, City or Town, State, Zip Code)  HMCKE MD 21223
O S 2 = 5 1 2 2 Cremation 3 □	20b. Place of Disponentery, cre	osition (Name of Date matory or other place)	20c. Location - City or Town, State
*4 Donation 5 Other (Special Service Lice)	,	MORIAL PARIL 8/30/05 2. Name and Address of Facility BEHS 139 No CAROLINE ST B.	
Physician   shock, or heert failure. List only   lmmediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not en one cause on each line.  a. DISSEMINATED  Due to (or as a consequence of):	ter the mode of dying, such as cardiac or resp	Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate case. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):		
S a s a s a s a s a s a s a s a s a s a		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
or Attending Physician: The law requires that the daffer death.  Director: After this certificate has been signed by the inpy the funeral director; page 2 stroud be detected by the funeral director; page 2 stroud be detected by the inpy the funeral director. Page 2 stroud be detected by the inpy the funeral director. Page 2 strong be detected by the inpy the funeral director.  The control of the control of the control of the inpy the inpy the inpy the funeral director. Page 2 strong be detected by the inpy the inpy the inpy that it is not control of the inpy that it is	ontributing to death but not resulting in the	inderlying cause given in Part I. 2	3e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4
Records, The law requires the has been sign to agge 2 should be completed by			4a. Was an autopsy autopsy findings available prior to completion of cause of death?  ☐ Yes 2 1  o
Physician: The Physician The Physician Ph	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Che	
1 Description of Death of Description of Descriptio	28a. Date of Injury (Month, Day Year) 28b. Time (Injury		Describe how injury occurred
DIVISION States of the property of the propert	28e. Place of Injury - At home, farm, si building, etc. (Specify)		ocation (Street and Number or Rural Route Number, ity or Town, State)
DIVISION  To the House after death.  To the Funeral or Attending within 24 hours after death.  To the Funeral or Attending investigation of the Funeral or Attending investigation or A	minar. On the basis of ausmination and/or is	th occurred at the time, date and place, and di evestigation, in my opinion, death occurred at l	the time date and place, and due to the equec(s)
29b. Signature and title of certifier	2	29c. License number M1 D 06 2 6 3 2 7	29d. Date signed (Month, Day, Year)  AUG 24, 2005
30. Name and address of person who	completed cause of death (Item 23a) (Type	Print)  MAPFIRE COLUMN	29d. Date signed (Month, Day, Year) AUG 24, 2005  BIA, MD 21045
State Registrar 31. Date filed (Month, Day, Year)	6 2005 Messas A	book	•

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 205 28058 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Wilson nichelle 5:10 PM Lynn 2005 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of manyland medical Center Baltimne If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 😡 F 217-04-1963 Director 24 19. 1981 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits or Itams 23a or 28a-f show the Medical Examiner must be notified at Maryland Harford 1 ☐ Yes 2 No Edgewood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1706 Judy Way 21040 death Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after arment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural; or Ite injury or othar traumatic avant, Ite Machical Exprising. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Legal Clerk Debt Collection Agency 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be David Keith Hunter Joan Carol Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan C. Via - Mother 106 Mountain Rd., Fallston, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens! 8-26-05 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses May 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician month disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** pneumonitis cute Interst Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) P.O. 9 Unknown ð Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 2 Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed 1 Yes 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Per 2 No Be 26. Place of Death (Check only опе) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA ate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Accident 5 Pending Injury after death.

Diractor: Af 1 ☐ Yes 2 ☐ No investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) J15948 30. Name and address of person who complet of cause of death (Item 23a) (Type, Print) Baltomre MD 21301 10 5 ecre

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 6 2005

32. Regitrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2015 28059 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Hansome 08 2005 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Baltimore Good Samaritan If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 30, 1920 Birthplace (State or Foreign Country) **Funeral** Months 10 M 2□ F 230-01-9892 85 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Ballimore 1 Yes 2 No by Funeral Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5610 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married I □ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ō Specify: Black 1 ☐ Yes 2 No 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Business Owner permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygient Important: if Iem 27 is marked other that any injury or other traumatic event, Irral 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carie Walker Jesse Goode 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of 5610 McComick Ave. Battimere, Maryland 19a, Informant's Name/Relationship (Type, Print) inda Walker durakter Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City o Jown, State Arbutus Mem. Arbutus 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of). Examiner squertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ventricular Due to (or as a consequence of) Examiner burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Sepsis Due to (or as a consequence of): Be Completed by Physician/Medical signed by the attending physid be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Infarction 24a. Was an Hypertension 2 No 1 Yes the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. RES-000 21/2005 who completed cause of death (Item 23a) (Type, Print) Jing Jiang

DHMH 17 Rev 1/2001

State Registrar 5601

31. Date filed (Month, Pay, Year) AUG 2 6 2005 Baltimore, Maryland,

BDulevard

32. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 0 0 5 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Austust 80 Robert Whelan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner 23 47 A THILES HOSPITA 5. Social Security Number 8. Date of Birth June 12, Year) 912 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days 218-07-9392 1 XM 2 ☐ F 93 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28e-f show the Mudical Examiner must be notified at 10d. Inside City Limits by Funeral Director Baltimore Catonsville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane, Apt. 123 21228 U.S.A. nit. Pages 1 and 2 should be filed within 72 hours after death artment of Health and Mental Hygiene. or ortant: If tem 27 is marked other than "naturel", or items 23 niqury or other traumatic event, Ite Moulcel Examine must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 XYes 2 □ No WW II If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Travel Agency 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked 4 any injury or other traumatic eventors. ပ Thomas Whelan Josephine Waring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. McKnight-nephew 605 Park Avenue, Apt. 7-C, New York, NY, 10021 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery 8/24/05 Baltimore, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final disease or condition resulting in death) with Liver Metastasco 0(an **Physician** (ancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Within 2 29b. Signature and title certifier 29d. Date signed (Month. Day, Year) 60060705

DHMH 17 Rev 1/2001

31. Date filed (Month Date AUG 2

211

State Registrar apan AVEOUELE

erson who completed cause of death (Item 23a) Type Print)

. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 0.051 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** MAE WILCOX ANNA AUGUST 24, 2005 10:08 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8032 Penwood Avenue Edgemere Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year) May 3, 1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F 214-22-1387 89 Yrs Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 📉 No MD Completed by Funeral Director Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8032 Penwood Avenue 21219 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Exercising 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Bernard Foulke Clara Fitzell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Taylor-niece 8032 Penwood Ave., Edgemere, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mausoleum B/26/05 \* 4 □ Donation 5 □ Other (Specify) Entendment Timonium. MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 Yark Rd., Tausan, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCATEAS **Physician** CARCINOMA of 10 mo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 20 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗋 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D16501 leman 8.24.05. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21204 DRIVE TOWSON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar

Certificate of Death

WEBB, CLAUDELL

NAME KNOWN

	Physic		1. Decedent's Name (First, Middle Claudell Wei									2. Date of De		, 2005	3. Time of Death 3:00 P M
	/Medi Examir		4a. Facility Name (If not instituti  VA MARYLAND HE	on, give stre		STEM	41			Location o		nagao		CECI	h
	Funeral Director		5. Social Security Number 214-18-4319	6. Sex	7. Age	(In yrs. last birt		f Under		If Under Hours		8. Date of Bir (Month, Da 8/14/	th 1914	Co	nplace (State or Foreig untry) ryland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. Count MD Ha:	rford		10c. City, Towr Edger		on						-	10d. Inside City Limits 1 ☐ Yes 2 🏝 No
	death with the Maryland ms 23s or 28e-f show	Funeral Director	10e. Street and Number 1950 Melvin A	venue				10f. Zip (		040			10g. Citiz	en of What Co	
2-0030	be filed within 72 hours after death with the Marylan tat Hygiene. Id other than "naturel", or tlems 23s or 28e-f show dother than "naturel", or tlems 23s or 28e-f show event, the Madical Examiner must be notified at	b	11. Marital Status  1X Never Married 2 Ma 3 Widowed 4 Divorce	rried	Was Decedent I Armed Forces? IN Yes 2 □ N If Yes, Give Year or Dates:			Decede s, speci Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: W	ncan Indian, o, etc. nite
0-01717	within 72 hours after iene. 'than "nature!', or Ite Ite Madles! Examine	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)		on <i>mpleted)</i> College (1-4or 5		life. DO	d of work	done a retired,	uring mosi	of working	ng		d of Business/I	ndustry
yland 2		To Be Co	17. Father's Name (First, Middle James Webb	o, Last)			110 V		VOIR	18. Mothe	r's Name ırah	(First, Middle, Dunn			
e, mar	₽ <b>£ 7:</b> ₹		19a. Informant's Name/Relation Terry Ruark	iship (Type,	Print)	19	950 M	lelvi	ln A		Edg	ewood,	Mary	Town, State, Z Land 2.	Ĺ040 
Dallimore	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other <u>9000</u> e.		20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5 Other  21. Signature of Huneral Service	Specify)	oval from State	20b. Place of cometer. Metro	cremato Crem	ory or oth naton	er place 'Y		8/25		Balt	imore, Funeral	own,State  Maryland  Home Inc.
20,000	Amendicate be executed attending physician and attending physician and for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease shock, or heart ailure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	st only one o	ACUTE M.  Due to (or as a  CORONAR.  Luc to (or as a	YOCARDIA Consequence of	ot enter that IN: of): I DIS:	re mode	of dying	, such as				[arylano	Approximate Interval Between Onset and Death UNKNOWN
.O. DOX		hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		lf yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □ Ect	opic pre her (spe	gnancy cify)				23	3d. Date of delin Month	very Day Year
olds, r	The law requires that the di ate has been signed by the bage 2 should be detached	by P	Part II. Other significant condit COLON CANCER,		•	•		lying cau	ise give	n in Part I.			obacco us /es 2 🗆		the cause of death?
ומו שבני	The lay ate has page 2	e Completed	STATUS POST FO		AMPUTA'	rion (Le	FT)			00.54		24a. Was autop perfor	rmed? 2 2 No	24b. Were aut prior to codeath? 1 Yes	opsy findings available ompletion of cause of 2 No
DIVISION OF VE	r Attending Phy er death. rector: After this by the funeral d	Certification; To Bo	examiner?  1 Yes No  27. Manner of Death  1 Valatural 5 Pend 2 Accident inves 3 Suicide 6 Could	Hosping 2	ital: 1 ☐ Inpatier 8a. Date of Injur (Month, Day 8e. Place of Inju building, etc	y 28b. T Year) In	me of jury	М	Work	<sup>7.</sup> 4 <b>X</b> Nur at	sing Hom 21	8d. Describe h	dence 6 now injury		fy) al Route Number,
	To the Hospitel or within 24 hours aft To the Funerel Discompletely filled in	edical	29a. Certifier 1 XCertify (Check only one) 2 Medica	ing Physicia I Examiner:	on: To the best of On the basis of and manner sta	examination and	death occivor investi	curred at	the time	e, date and nion, deat	l place, ar h occurred	nd due to the d d at the time, d	cause(s) a date and p	nd manner as :	stated. the cause(s)
	or with pos	M	29b. Signature and title of certification of the Policy of	Ja	who i	25.00	Tune D	]		number 94-1	NY			signed (Month)	
	Sta	to.	30. Name and address of person  MELECIA SA  31. Date filed (Month, Day, Yea.	NTOS,	M.D., V				H C	ARE S	YSTE	M, PERR	RY PO	INT, MD	21902
24	Registr		AUG 2 6 2		Galya		barte	1							

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health a  1- Stete Registrar Certificate of Death		ental Hygie	ene 0 (	05	28063				
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death				
	/Medic Examin	al	John Thomas David Young Sr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of		August	4c. County	Sec 5	545 p M				
	Lxaiiiii	iei	BAltimore WAShimton Med. CTR Glen Burn			Anne		inde/				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 215 – 34 – 8028 1CXM 2 F 67 Yrs. 67 Yrs.		Date of Birth	92038	9. Birthpl Coun	ace (State or Foreign				
	ъ		Usual Residence of Decedent		7011. Z7	1330		IX I				
	larylan show	ž	10a. State   10b. County   10c. City, Town or Location   Marvland   Anne Arundel   Millers	villo			10	0d. Inside City Limits  1 Yes 2 No				
	the N	Director	Maryland Anne Arundel Millers  10e. Street and Number 10f. Zip Code	sviite		. Citizen of V	Vhat Coun					
	th with		273 Severn Road 21108	3			USA	,				
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event. The Medical Examiner must be multified at ODEs.	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:  13. Was Decedent of Hispanic Orig  If Yes, specify Cuban, Mexican  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No  Specify:		fy Yes or No- can, etc.)		e · America k, White, e : Wh					
5-0	72 ho 'natur	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	st of working	16	Sb. Kind of Bu	ısiness/Ind	ustry				
121	within ene. than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+) IIIe. DO NOT use retired)  12 Mechanic	J		Truc	kina					
nd 2	e filed al Hygi I other vent, I	Be Co	17. Father's Name (First, Middle, Last) 18. Mothe		First, Middle, Ma	iden Sumam	10)					
yla	Menta Menta Marked Marked	101		ggie		Robert						
Baltimore, Maryland 21215-0036	nd 2 sh Ith and 27 is n		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Barbra I. Young (spouse)  273 Severn Road,					Code)				
ore,	of Hea		20a Method of Disposition 20h Place of Disposition (Name of		20 20	c. Location -	City or Tox					
ţ	ment tant: fi		'4 Donation 5 Other (Specify)	2005		ltimor	e, Ma	aryland				
Bai	permit Depar Impor any in		21. Signatur of Foreira Servic Librigee 22. Name and Address of Facility 3111 Mountair	n Roac		lena, №						
	AVE THESE		23a. Part1. Enter the disease, or complications tilat caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one dause of each line.	cardiac or r	espiratory arrest	t,		Approximate Interval Between Onset and Death				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Lung (Ancer Due to (or as a disease of):									
ľ	Examiner											
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
<u>_</u>	cate be executed bhysician and the burial-transit	Examiner	that initiated events c									
8760,	ate be nysicia he bur	dlcai	d									
9	entifica	/Med	IF FEMALE:									
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy 1   1   Live birth 2   Fetal death 3   Ectopic pregnancy   5   Other (specify)   1   Unknown   5   Other (specify)   1   1   1   1   1   1   1   1   1			23d. Date Mor	e of deliver nth [	y Day Year				
<b>a</b>	res that igned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobac	cco use contr	ibute to the	cause of death?				
ord	w requir been si should I				1 Yes	2 🗆 No	3 🗍 Proba	bly 4 Dunknown				
Vital Records,	ilcian: The law certificate has b rector, page 2 s	e Completed				d? d	Vere autop rior to com eath?	sy findings available pletion of cause of				
	% ≤ G	To Be	Hospital:		Check only one) 5 ☐ Residence	e 6∏Othe	r (Specify)					
Division of	ing Ph		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	280	d. Describe how							
Sio	Attendi death. ctor: A y the fu	Icat	2 Accident investigation   M   1 Yes 2 No   3 Suicide   6 Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number.									
<u>&gt;</u>	s after s after al Dire	Certification:	4 Homicide determined building, etc. (Specify)	201	City or Town, S		or Hurar	noute reamber,				
	he Hospi n 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	d place, and th occurred	d due to the caus at the time, date	se(s) and mar and place, a	nner as sta	ted. he cause(s)				
	\	Σ	29b. Signature and title of certifier  Hey 7n Ms  29c. License number  D0274	15		Date signed		ay, Year)				
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HENRY FRANCIC MD., BALTIMINE WAShington	, M-	dient 1	PATI						
	Sta		31 Data filed (Month Day Vear) 32 Begintrat's Signature									
DHI	Registra	Registrar  AUG 2 6 2005  Rev 1/2001										

State of Maryland / Department of Health and Mental Hygien 2005 28064 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 24, 2005 **Physician** 11:00 A M Mary I. Yaeger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3727 Lyndale Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 X F Yrs. 237-30-6079 Director 80 1925 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or Items 23a or 28e-f show other traumatic event. The Michigal Examiner must be notified at 1X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3727 Lyndale Avenue 21213 Funeral u. S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: δ If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wallace Jones Margaret Tennant ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susanne Crigger (daughter) 3727 Lyndale Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 Cremation 3 Removal from State ŏ ' 4 ☐ Donation 5 ☐ Other (Specify) injury Gardens of Faith 8/27/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3ny 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3331 Brehms Lane, Baltimore, Maryland 21213 Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 10a15 ORDNAR disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, any leading temperature and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit PERTEN Due to (or as a consequence of): Box 68760 Physiclan/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Yes 24a Was an has autopsy performed? /es 2 No 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident in by the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier ucharl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENNINGTON AUE 4710 15HEV2 KICHARD 31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28065 For Stete Registra Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Year George F. **Physician** 5:408 M 13 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Levindale Hebrew Geriatric Hospital Baltimore No County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | U. J. 17, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months 87 ΜĎ 215-01-1258 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other treumetic event, the Medical Examiner must be notified at Be Completed by Funeral Director 1X Yes 2 □ No Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14001 Lighthouse Ave. Items 23e 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò Specify: White 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3 X Widowed 4 □ Divorced 'naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry it of Health and Mental Hygiene.
If item 27 is marked other then or other treumetic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Owner-Operator Package Goods Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward F. Ay Martha Lerian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Ay 1906 Old New Windsor Rd., New Windsor,Md. 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. A □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 8-15-05 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home Service Licensee 108 William St., Berlin, Md. 21811 ulas 23a. Part1. Enter me/disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** entricular acr he disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Schemu Canol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 mv by Physiclan/Medical Examiner Due to (or as a consequence of). or Attending Physicien: The law requires that the death certificate be executed the burial-transit Carsnarn Due to (or as a consec for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 No 011 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an penphera mattiple 2 No deembiti Mus Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Manner of Dean 1 Natural 2 Accident in by the funeral D te f Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death. 1 Yes 2 No investigation 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 24 hours a filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Commedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 60 MIT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. Belvedere Ave. C.H. 6+1 Cerindale SIL DWN istrar's Signature State Registrar

			1 - For State Registrar	State of Ma	ırylanı	d / Depa	artment of F	lealth ar Death	nd Mental F	ygiene Reg. No	2005	280	66
I	Physici		Decedent's Name (First, Middle, La Shirley	ast)	Ald	derson			2. Date of Month Augu	Da	2005	3. Time of De 1425	eath M
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, given the facility Name (If not institution), given the facility Name (If not instit	rt Hosi	Oit a	ast birthday) Yrs.	4b. City, Town, o	Der L	and		County of Deat		oreign
	Aaryland f show ed al	or	10a. State 10b. County MD Allega	ny	10c. City	Town or Lo	cation perland					10d. Inside City L	_
	or 28e-	Direct	10e. Street and Number	-	4.		10f. Zip Code	0.4.5.00		10g. Ci	tizen of What Co	^	
5-0036	be filed within 72 hours after death with the Maryland lal Hyglene d othar then "natural", or Items 23e or 28e-f show avent, the Mcdreal Examiner must be notified at	by Funeral Director	11821 Bayberry A  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N				21502 lispanic Originan, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	USA  14. Race - Ame Black, White  Specify: Whi	e, etc.	
	thin 72 ho e. en "natur Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5-		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most o d)			(ind of Business/		
12 12 pi		Be Con	12 17. Father's Name (First, Middle, Las.	)		Assista	ant Superi		ent s Name <i>(First, Mid</i> o		road Sumame)		
Maryland		To B	Norman Alders						ces Lane				
	od 2 strau		19a. Informant's Name/Relationship Margaret Alderson				21 Bayber		or Rural Route Nur nue Cun	nber, City o		D 21502	
altimore,	000-		20a. Method of Disposition  1 X Burial 2 Cremation 3		ce	emetery, crei	sition (Name of matory or other place Paul Cemet		Date 8/24/200	-0	ocation - City or i		
Baltin	permit. Pag Department Importent: I eny injury o		4 □ Donation 5 □ Other (Special Service Lice		70=		Name and Addre Scarpell	ss of Facility i Funera	ıl Home, PA				
8760,	Certificate be executed  Wedical Medical Medic	Ical Examiner	23a. Part1. Enter the disease or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each lin	e.  A CONSEQUE  CONSEQUE  CONSEQUE	M 7 (ence of):	er the mode of dyir	ng, such as ca	enue: Cumb ardiac or respiratory for for for for for for for for for for	arrest,	MD 2150	Approximate Interval Betwee Onset and Dea	ıth
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 Fetal	death 3[	Ectopic pregnancy	,			23d. Date of deli Month	very Day Year	r
ds, P.	as tha	by	Part II. Other significant conditions	contributing to death bu	it not resu	Iting in the u		en in Part I.		d tobacco i		the cause of death	
Vital Hecords,	The ate ha	e Completed	Aorte Diabet	Steno		1 +25			pe 1 ☐ Yes	topsy rformed? 2 - No	prior to death?	topsy findings avai ompletion of cause 2 No	ilable e of
ot VII	Physicia this certi	To Be	25. Was case referred to medical examiner?  1  Yes 2 10	Hospital:		R/Outpatier	it 3 DOA Oth	0.5	f Death <i>(Check on)</i> ing Home 5□Re		6 □Other (Spec	ity)	
Division c	ding h. After funel	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigated 3 Suicide 6 Could not be			28b. Time of Injury	M 1	yat k? Yes 2 ☐ No				13	
<u>&gt;</u>	tal or Al	Certifi	4 Homicide determined		ry - At hoi : (Specify	me, tarm, str )	eet, factory, office			(Street an own, State		ral Route Number,	,
	To tha Hospital or Attan within 24 hours after deatl To tha Funarel Diractor: completely filled in by the	edical	29a. Certifier 1 ★ Certifying P (Check only one) 2 ★ Medical Exe	hysician: To the best of miner: On the basis of and manner star	examinati	vledge, deatl ion and/or in	n occurred at the tin vestigation, in my o	ne, date and p pinion, death	place, and due to the control occurred at the time	ne cause(s e, date and	) and manner as d place, and due	stated. to the cause(s)	
	With To I	M	29b. Signature and title of certifier		m		29c. Licens		5		te signed (Month CAUSTZ		15
	Ġ.	_	Thomas Chapp	ompleted cause of de	912	Seto	Print) Drive	Cu	5 mberlan	d, 11	10 215	03	
	Sta Registr		31. Date filed (MATH Pay 2 %) 20	3 Registra	, J	Long	ale .						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005 28067 Amend item#9arte18 perFH, FCHD/dc 8/23/05 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August **Physician** 13° 2005 11:42A M Michael Gilbert Belgrave /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll County General Hospital Carroll Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 3, 9. Birthplace (State or Foreign Country) Guyana 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1944 Months Days Hours 1 ₹M 2 □ F 60 083-40-2852 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shorthe Woolcal Experiment ust be notified at 1 ☐ Yes 2 XNo Directo Maryland Carroll Mount Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5881 Moss Creek Drive 21771 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wire Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other treumatic event, ITE 2006. Systems Analyst Private Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Yvonne Hugo Gilbert Belgrave <del>Yvon</del> Hodgeson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5881 Moss Creek Drive, Mount Airy, Maryland 21771Dana C. Belgrave - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematorium 8/19/05 Alexandria, Virginia \* 4 □ Denation 5 □ Other (Specify) Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 21. Signature of Furieral Service Licenspe d 20872 overt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR I refoun Priysician FIBRILLATION /Medical Due to (or as a consequence of): Examiner Myecard How Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760. death certificate be Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 TYes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 D No 3 DOA 27. Mann of Death 1 atural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; al or Attanding F after death. I Director: After After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Colutablede D18900 NACIANMA. ND 700-A podle 2d went minutes ND 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRACHEDU 2 Registrar's Signature State Registrar

Amended Item 5 per F.D. 08/18/2005 Carroll County, wjl Amended Item 11 per F.D. 08/15/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. NZ 005 28068 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 09 2005 Margaret Lorraine Bresnahan August 3:15 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 1422 Cotton Drive Westminster Carroll If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. **578**5918145553 **Funeral** Months Days Hours 1 ☐ M 2 ☐ 4F Min Director Yrs. 5<del>79-05-7001</del> 84 04 1920 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ral', or itema 23a or 28a-f ahov Examiner must be notified at Completed by Funeral Director 1 TYes 2 TWO MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itema 23s or 2 any injury or other traumatic event, the Medical Estate with most term 21157 1422 Cotton Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. 3 XWidowed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Government Printing Elementary/Secondary (0-12) College (1-4or 5+) Office 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John A. Elliott Margaret L. Kirkland 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Moroz/niece 1422 Cotton Drive Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Pk | 8/11/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) neumani G /Medical Due to or as a consequence of): **Examiner** 10 ment Sequentially list conditions if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed is should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 500 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 🗆 No Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the within 24 hours after deatl

To the Funeral Diractor:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie WJL ano 10058137 address of person who impleted cause of death (Item 23a) (Type, Print) 30. Name an 8 307 Westminster Storer 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Division of Vital Records,

Glown It Sparke

Physician /Medical Examiner

**Funeral** Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or items 23a or 28e-f show any injury or other traumatic event, if a Medical Examinar must be notified at aging.

Baltimore, Maryland 21215-0036

			le ink. Ensu					
1 - For State Registrar	State of Maryland	d / Departme Certifica	ent of Health a ate of Death	R	eg. No.	05 28069		
1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death		
Leonard Sa	anford 1	Boxley		August		005  12:55 A M		
4a. Facility Name (If not institution, give s	treet and number)	4b. Ci	ty, Town, or Location of	of Death	4c. County o	Death		
Southern Maryland  5. Social Security Number 6. Sex			Clinton  der 1 Year   If Under	24 Hrs. 8. Date of Birth		e George's  9. Birthplace (State or Foreign		
227-58-4479	M 2□F 61	Yrs. Month		Min. Mov. 28	, 1943	Virginia		
Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince	ce George's	Town or Location	ton-Capi	tal Height		10d. Inside City Limits 1 ☐ Yes 2 ▼No		
10e. Street and Number		10f.	Zip Code	1	0g. Citizen of Wh	nat Country?		
328 Possum Court	t	2	0743		U.S.A.			
11. Marital Status  1 X Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.\$ Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		cedent of Hispanic Ori pecify Cuban, Mexicar 2 X No Specify:	gin? (Specify Yes or No- i, Puerto Rican, etc.)	Black	- American Indian, White, etc Black		
Maryland Prince George's Clinton_Capital Heights   1								
17. Father's Name (First, Middle, Last) Unknown				er's Name (First, Middle, I tha Boxley	Maiden Sumame			
19a. Informant's Name/Relationship (Type Veronica Pratt-I				or or Rural Route Number Capital He				
20a. Method of Disposition	Ce	ace of Disposition (f	vame of	Date	20c. Location - C	ity or Town, State		
21. Signature of Funeral Burvice License	MO13:		and Address of Facilit	10/19 Co		se Rd ,VA 22407		
23a. Part1. Enter the disease, or complications, shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death le cause on each line.  Complication  Due to lor as a consequ	s of perti	ode of dying, such as	cardiac or respiratory arri		Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ranca of):						
that initiated events resulting in death) Last	Due to (or as a consequ							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic	pregnancy (specify)		23d. Date Mont	of delivery h Day Year		
Part II. Other significant conditions con	tributing to death but not resu	Ilting in the underlyin	g cause given in Part I			oute to the cause of death?		
				24a. Was a autops perform	ned? pr	ere autopsy findings available or to completion of cause of ath?  Yes 2 No		
25. Was case referred to medical			26. Place	of Death (Check only on	(e)			
examiner? 1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending	ospital: 1 Vinpatient 2 1 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	DOA Other: 4 Nu 28c. Injury at Work?	rsing Home 5 Reside	ence 6 Other			
2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fact	1 Tes 2	28f. Location (St	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be executed

within 24 hours effer death. To the Funeral Director: After this certificete hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

DHMH 17 Rev 1/2001

Tashu Z Groenherg 31. Date filed (Month, Day, Year) AUG 2 6 2005

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature

29d. Date signed (Month, Day, Year)

August 15, 2005

**ORIGINAL** 

29c. License number

O.C.M.E.

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** <u>4:</u>30 a Roderick Donald Beach August 10, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bedford Court Nursing Home Silver Spring Montgomery if Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 183 M 2 □ F Director 048-20-7738 78 Nov. 18, 1926 Connecticut Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and them to them \$250 or 280-f show ant: If item 27 is marked other then "naturel", or Items 230 or 280-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 XYes 2 No Completed by Funeral Director Hart.ford Connecticut Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 45 Hartland Terrace 06037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 (12) Yes 2 □ No If Yes, Give Year or Dates: Koreā 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpecifyWhite 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Korea 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Customer Engineer ont of Health and Mental Hygint: If item 27 is marked other yer other treumetic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick R. Beach Eleanor Harrison ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen L. Beach/ Daughter 14202 Long Green Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place August 11 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or Metropolitan Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, Md 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, lany, leading to in recliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 \( \sum \) Yes 2 \( \sum \) No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Heart 1 Yes 2 No 3 Probably 4 No Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perfor 1 Yes 2 No 1 Yes director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Satural
2 Accident death. investigation after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 D50545 8 + New Hauphore Are 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7513 OKOJI GODSWILL MD Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrer Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10°, 2005 **Physician** AUGUST ROSE SABINA COLLINS 12:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 360 OLD BACHMANS VALLEY ROAD WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** OCTOBER 27,1915 Months Days Hours 1□ M 27 F Director 103-18-1623 89 NEW YORK Usual Residence of Decedent the Maryland 10a, State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahov The Medical Executeer must be notified at MARYLAND CARROLL WESTMINSTER 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itams 23a 360 OLD BACHMANS VALLEY ROAD 21158 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. hours after ☐Yes XX No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes → No Specify: þ Widowed 4 □ Divorced Specify: WHITE "natural", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) 6 HOMEMAKER DOMESTIC permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic ances 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PETER JOHN ZERUCHA ANNA KOSZYK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN GANN/DAUGHTER 3367 OLD LINE AVENUE, LAUREL, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State CARROLL CRÉMATION 08/11/2005 HAMPSTEAD, MARYLAND `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligense 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. WESTMINSTER, MD proximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Pulmonan 5 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The taw requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 2. No 2 No 1 ☐ Yes Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 9 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H53939 AUGUST 10, 2005 WIL De 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 218 WASHINGTON HEIGHTS MEDICAL CENTER, DR. BABAK IMANOEL WESTMINSTER, MD 21157 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 1 1 2005

			State of Maryland / Department of Health and I  State Registrar  Certificate of Death	Mental H	ygien 20	280 <b>72</b>			
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of D Month		3. Time of Death			
	/Medic	al	Lowell Arnett Cooper	Augus	t 21 2	79ап 2005 1115 м			
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Upper Chesapeake Medical Center  Bel Air	n	4c. County	ford			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of E	Rirth	9 Birtholace (State or Foreign			
	Director		217-34-0718   '\(\frac{1}{2}\text{T}\)   67   Yrs.   1	May 2	7, Year 938	West Virginia			
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits			
	Mary a-f sh	tor	Maryland Harford Edgewood			1 ☐ Yes 2 🛣 No			
10	death with the Maryland oms 23a or 28a-f show ir must be notified at	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of W	-			
1	s 23a	rall	638 Boxelder Drive 21040	- 7 1	U.S.				
	ter de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent of Hispanic Origin? (S H Yes, specify Cuban, Mexican, Puert	pecify Yes or it o Rican, etc.)	No- 14. Hace Black	- American Indian, k, White, etc.			
036	ours at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates: U.S. Navy		Specify: White				
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	rking	16b. Kind of Bus	siness/Industry			
121	within ene. than	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Education Specialist		Civil Se	ervice			
\sigma \frac{1}{2}	othar	BeC		ne (First, Midd	le, Maiden Sumame	3)			
o la	wild be Menta arkad atic ev	To B	Shirley Cooper Marga	aret An	n Graham				
8/21/05	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event. The Medical Exercities investore investore notified at once.		19a. Informant's Name/Relationship (Type, Print)  Lula Ann Cooper (Spouse)  19b. Mailing Address (Street and Number or Ru 638 Boxelder Dr., Edge			State, Zip Code) 21040			
000	1 and Health		Lula Ann Cooper (Spouse) 638 Boxelder Dr., Edg.  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	-	City or Town, State			
ō	Pages ent of nt: If it		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  R. A. Ferris & Co. 8/23	/05	West Che	ester, PA			
Saltimore	mit. I partm portal y inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Induction Application of Maryland Application (Maryland Application).	•	me.P.A.				
_	82558		Low- This told wind						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each the.  Immediate Cause (Final	or respiratory	arrest,	Approximate Interval Between Onset and Death			
Pnysician /Medical			Immediate Cause (Final disease or condition resulting in death)  a	in		1 3/2			
	Examiner		Van O and a committee	hos	is	loyers			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						V			
_	be executed ician and burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
11	te be execu ysician and ne burial-tra	calE	d			ė.			
\$ G	tiffica ng ph as th		IF FEMALE: 23c. If yes, outcome of pregnancy						
O.W.	death certifica e attending ph d for use as th	23d. Date Mon	of delivery th Day Year						
70		Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						
per Is. P	, 5, 5, 8	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?					
200 good	v require been sig	ted	covary and assesse	1	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Orfknown				
Coope Records.	e lawr has be	Completed			is an 24b. Woopsy promed?	Vere autopsy findings available rior to completion of cause of eath?			
	n: Th ficate or, pag		25. Was case referred to medical 26. Place of Dea	1 ☐ Yes	2 No 1	Yes 2 No			
	Physician: r this certifica ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No			r (Specify)			
9/9 n of	ng Ph fter th	T :uc	27. Manner of Death 1 Natural 5 Pending (Month, Day Year)   28b. Time of   28c. Injury at   28c. Injury   28c. Inj	28d. Describe how injury occurred					
190191	ttendi death. tor: A the fu	icatl	2 Accident investigation M 1 Yes 2 No	(Street and Numbe	r or Dum I Douto Number				
y o	after after Direct d in by	Certification;	4 Homicide determined determined building, etc. (Specify)	determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number building, etc. (Specify)					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier  (Check only  Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur	, and due to th irred at the time	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)				
	o the ithin 2 o the omplet	and manner stated.  29c. License number 29d. Date signed							
	⊢ 3 ⊢ ŏ		Me CONSULTANT D. 1644	4.	Angust 21-2005				
	1xs		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  VIJAY- S. NAIR, 602-S. Atwood R	Rel.		1221014.			
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 5 2005  32. Registrar's Signature						

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

bean & Sports

			For State Registrar	State of Ma	aryland / I	•	tment of ificate of					005	2807	+
	Physici		1. Decedent's Name (First, Middle, Last) Dorothy M.		Elder					2. Date of De Month August	Day	Year 2005	3. Time of Death 6:00 a M	ı
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		- 4	4b. City, Town,	or Location	n of Death	114945	<del></del>	ounty of Death	0.00	_
		•	3118 Gracefield Ro	oad, #CCT	01			er Spi			Mo	ntgomer	y	
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last bi		If Under 1 Yea Months Day			8. Date of Birt (Month, Da	y, Yea <i>r)</i>	Cou	place (State or Foreign ntry)	
	Director		577-01-2763 Usual Residence of Decedent	242	90	Yrs.				June 14	, 191	5 Wash	ington, DC	
	land land		10a. State 10b. County		10c. City, Tow	vn or Loca	ation				10d. Inside City Limits			_
	Many First	tor	Maryland Montgome	ery	Silv	er S	pring						1 ☐ Yes 2 🛣 No	
	or 28	Directo	10e. Street and Number				10f. Zîp Code				10g. Citize	n of What Cou	ntry?	
	ath w		3118 Gracefield F				209					USA		
36	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show calcal Examination and the modified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2230 If Yes, Give			as Decedent of Yes, specify Cu ☐ Yes 21☐ N			ecify Yes or No Rican, etc.)	}	. Race - Ameri Black, White, pec <i>ify:</i> Whit	etc.	
Maryland 21215-0036	tural	ed b	15. Decedent's Educ	Year or Dates:	16a	a. Deceder	nt's Usual Occ	upation			16b. Kind	of Business/Ir	ndustry	
15	within 72 ene. than "na'	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed)		(Give kir	nd of work don NOT use reti	e durina m	ost of work	ing	100.11.11	0. 540004	.adotty	
212	d with giene ar tha	E O	Elementary/Secondary (0°12)	College (1-4or 5	)+)	Telep	phone E	Execut	ive		Tele	ohone C	ompany	
2	be filed within 72 ho Ital Hygiene. ed other then "netur event, Ite Madical	Be C	17. Father's Name (First, Middle, Last)							e (First, Middle,		umame)		
<u>Xa</u>	Ment Ment arkec	To	William F. Marsh	5-6						ce F. Ma				
<u>Jar</u>	12 sh and rism		19a. Informant's Name/Relationship (Typ		198	b. Mailing	Address (Stree	et and Num	ber or Rur	al Route Numbe	er, City or 7	own, State, Zi	o Code)	
e,	1 and Health		Robert H. Caho/ C	ousin	20b. Place o	of Disposit	tion (Name of			stown. V		120 tion - City or T	own. State	
ltimore,	ages and a second		1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemete	ery, crema	itory or other participations of the comparison			st 13,				
틀	permit. Pages 1 and 2 should be filed will Department of Nealth and Mental Hygian Important: If itam 27 is marked othar th any injury or other traumatic event, Its once.		*4 □Donation 5 □Cther (Specify)  21. Signature of Funeral Service License	90	,					005 Funeral			ng,Marylar	ıd
Ba	per Dep Imp	. 1	MoneMar	wepart	cer								, MD 20901	1
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	d the death. Do							Spring	Approximate Interval Between	_
3	- Pnysician	2 11	Immediate Cause (Final disease or condition	Chronic		ctive	Pulmo	narv	Digos				Onset and Death	
1	/Medical		resulting in death)		a consequence		2 Tuliio	ndry	DISCO	ise				-
	Examiner	_	Sequentially list conditions, b	South from										
	ed isit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	o 17.								
	be executed sician and burial-transit	xan	that initiated events cresulting in death) Last	Due to (or as	a consequence	of):								
8760	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai E	d	1.										
9	uficate g physi as the t	ledic												
ŏ	eath certific attending p	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome 1□Live birth	of pregnancy 2 Fetal death	h 3□ <b>E</b>	ctopic pregnan	icv			23	d. Date of deliv	,	
O. B	e deal he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			Other (specify)					Month	Day Year	
<u>Ч</u>	nat the de d by the a letached i	Phy	9 ☐ Unknown  Part II. Other significant conditions con	stributing to death h	eut not reculting	in the und	larhina cauca	awan in Par	+ I	23e Did to	nhacco use	contribute to t	he cause of death?	
ŝ	uires that signed k	l by	Pulmonary Hyperten					giveiriir ai	. 1.		/es 2□		pably 4 Unknown	1
Records,	w requ	Completed	Congestive Heart F							24a. Was			opsy findings available	
Rec	has ge 2	mp		dirare						autop perfo	rmed?	prior to co death?	mpletion of cause of	,
Viita			25. Was case referred to medical					OF Dia	on of Dont	1 ☐ Yes h (Check only o		1 🗆 Yes	2□ No	
>	2 (/) 73	o Be	examiner?	lospital:	ent 2 □ ER/O	utpatient	3□ DOA	thos		me 5√2 Resid		Other (Speci	fy)	
Division of	ding Phy h. After thii funeral c	n: T	27. Manner of Death	28a. Date of Inju	rv 28b.	Time of	28c. In		-	28d. Describe				ī
201	vttendin death. ctor: Af y the fur	atio	1 X Natural 5 ☐ Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,,		□Yes 2	□No					
Ž	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, fac. (Specify)	arm, stree	et, factory, offic	е		28f. Location (S City or Tox		Vumber or Run	al Route Number,	
	oital o			1	-1						(-)			
	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examir		f examination ar									
	To the within 2 To tha complet	Me	29b. Signature and Ittle of certifier				29c. Lice	nse numbe	r		29d. Date :	signed (Month,	Day, Year)	
	/		· All	4			D	24035			Augus	t 11, 2	2005	
	>		30. Name and address of person who co	mpleted cause of c								-		
			Eugenio S. Machad					oad,	Silve	r Sprin	g, MD	20904		
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 1 2 20	32. Higistr	rar's Signature	Sol	cale							

State of Maryland / Department of Health and Mental Hygien 2005 28075 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Fauntleroy Lou 2005 11, 9:00 PM August /Medical 4c. County of Death Frederick 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Braddock Heights Vindabona Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 3 TXF Yrs. June 9,1926 79 Kentucky Director 578-28-1972 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r then "naturel", or items 23a or 28a-f show the Modical Examinar must be notified at 1 Yes 2 No Braddock Heights Maryland Frederick Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21714 6012 Jefferson Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. primit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiane. Important: If item 27 is marked other then "naturel", or ite any jury or other traumatic event, the Model Examine of a 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White **≥** 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Human Resource Director Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ricci Margaret Plank 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1223 Hoffmaster Road, Knoxville, MD 21758 Ann Hinerman/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 18/14/2005 Frederick Crematory Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Weeks disease or condition resulting in death) Drieumonia /Medical Jue to (or as a consequence of) Examiner Suspected CHECES lung Sequentially list conditions, I any, leaving to innectalle cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Ultherner's dementio 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown certificate has been Seizure disorder 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1 ☐ Yes : After this certification : After this certification : o the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tes \_2 **√**No 2 ER/Outpatient 3 DOA 4 ✓ ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie f 🚾 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kathleen 8/12/05 1032073 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Brunswick 610 NMH 31. Date filed (Month, Day, Year) State AUG 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28076 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 2140 DOROTHY VIRGINIA 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HICOMICO Peninsula Regional Medical 30/13/1/1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Yrs Director 213-22-6023 03-16-1927 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: if item 27 is marked other than "natural", or itams 23s or 28s-f shov injury or other traumatic event, the <u>Nacical Examinar must be politied al</u> 1 Fes 2 No Directo Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 S. Camden Avenue 21826 United States death Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental Thomas J. Long Virginia Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. Alton F. Figgs, Sr. /Husband 110 S. Camden Avenue, Fruitland, Md. 21826 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 08-12-05 Princess Anne, Md. Beechwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home, PA. 11673 Somerset Ave, Princess Anne, Md. 21853 MO0295 a.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** <1 L /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ίç in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performer 24b. Were autopsy findings available prior to completion of cause of death? page 2 s After this certificate has 1 ☐ Yes 2 No 2 No 1 🗌 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred I or Attanding Fatter death. 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours after To the Funeral Dis 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0061327 me of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Dalisbury 100 Pou 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2**0**05

State of Maryland / Department of Health and Mental Hygien 2005 28077 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10, 9:50 P M Barbara Jean Greenough August 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 T F Yrs. Director 213-50-9672 80 Dec 19, 1924 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Ever-instruct by notified at 1 XYes 2 ☐ No Director Maryland Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 616 Aster Boulevard 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 le marked other then "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify. White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nevell Richard Jones Mina R. Getman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice L. Greenough/husband 616 Aster Boulevard Rockville, ND 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Importent: If itel
any injury or ott 20c. Location - City or Town, State August 12. 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 2005 Odenton, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Astrocytoma - Cerebral /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine by the attending physician and tached for use as the burial-transit The taw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 90 1 ☐ Yes 2√☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  Other (Specify hospice) d d 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the 29b. Signature and titl 29d. Date signed (Month, Day, Year) 041218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

/!'' 1 5 2005

Charles Harrison M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

		•	For S  Sequence of the sequenc	tate of Maryland / D	Department of Head Certificate of De		ntal Hygier	7 111114	28078
	Physicia	an	1. Decedent's Name (First, Middle, Last) Hattie	lae Hurley			. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stre		4b. City, Town, or Lo	ocation of Death		4c. County of Death	
	Funeral		Anne Arundel Med 5  5. Social Security Number 6. Sex	7. Age (In yrs. last birt		f Under 24 Hrs.   8	Date of Birth	Anne Aru	lace (State or Foreign try)  n., D.C.
	Director		219-38-4905 1LM Usual Residence of Decedent	<sup>2</sup> √ 65	Yrs.	I I I	(Month, Day, Yes	[940  Was	i., D.C.
	faryland ed at	ō	10a. State 10b. County Anne Maryland Arundo		or Location Dunki:	rk		1	0d. Inside City Limits 1 ☐ Yes 2 X No
	or 28a-	Director	10e. Street and Number 413 West McKendi		10f. Zip Code 20754	/.	10g. (	Citizen of What Coun	itry?
	death w	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Speci	ify Yes or No-	14. Race - Americ Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show amy injury or other treumette event, the Medical Extr. ill afficiant te incillised at ODGe.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes 21 No If Yes, Give Year or Dates:		Specify:	ouri, oto.,	Specify: B1 a	
21215-0036	n 72 hou "neture	Completed	15. Decedent's Educati (Specify only highest grade $\alpha$	empleted)	Decedent's Usual Occupation (Give kind of work done dur life. DO NOT use retired)	on ring most of working	7	Kind of Business/Ind	•
212	led withi lygiene. her then it, its M		10	College (1-4or 5+)	Domesti		I	lome	
land	uld be fil Aental H rked ott tic even	To Be	17. Father's Name (First, Middle, Last)  Lewis Wesl	ey Estep	_	8. Mother's Name ( Mary	First, Middle, Maid	Riggs	
Mary	d 2 shorth and No. 17 le mattreume	1 8	19a. Informant's Name/Relationship ( <i>Type</i> , Estep Hurley/Hus		Mailing Address (Street and 3 West McKe				
ore,	ges 1 an of Heal If item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Place of cemeter	Disposition (Name of y, crematory or other place)	Da	te 20c.	Location - City or To	wn, State
Baltimore, Maryland	mit. Pag bartment cortent: rinjury c		`4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Union	UMC Cem.	8/15/	-		nding, MD
ä	P P P P P P P P P P P P P P P P P P P		23a. Part 1. Enter the disease, or complicate	Servell	1451 Dares			ncë Fred	ne 1.,MD2067
	Pnysician		shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ause on each line.	Ke			C	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disase of Ajur) that initiated events c	Due to (or as a consequence	of):				
30,	cate be executed obysician and the burial-transit	I Exar	that initiated events c resulting in death) Last	Due to (or as a consequence	of):				
68760,		Aedical	d						
D. Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23c.  23c. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		D - 48 - 4 - 40	23d. Date of delive Month	ory Day Year
s, P.O.	ires that the designed by the	by Phy	Part II. Other significant conditions contril		n the underlying cause given	in Part I.		o use contribute to th	,
cord	v require been sig should b	leted l	Breat La	INCF			1 ☐ Yes 24a. Was an	2 No 3 Prob	ably 4 20nknown psy findings available
Vital Records,		Completed					autopsy performed 1 Yes 2	prior to cor death?	npletion of cause of
	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hos	pital: 1. Inpatient 2 □ ER/Ou	Other	26. Place of Death (		6 ☐ Other (Specifi	y)
o uc	ing After une	tion: T	1 Natural 5 ☐ Pending		Fime of njury a Work?  M 1 ☐ Ye		d. Describe how in	njury occurred	
Division of	or Atten ifter deaf Director: in by the	Certification:	2 Could not be	28e. Place of Injury - At home, fa building, etc. <i>(Specify)</i>			3f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in h	edical C		an: To the best of my knowledge : On the basis of examination an					
	To the within 2 To the comple	Med	29b. Signature and title of certifier	2 // 12	29c. License r	number	29d.	Date signed (Month,	Day, Year)
•	-		30. Name and address of person who come	pleted cause of death (Item 23a)	(Type, Print)	51501	A	Vyust 1	0, 204
	5		Tem & Knoft  31. Date filed (Month, Day, Year)	oleted cause of death (Item 23a)  32. Registra's Signature	Potyate	RJ # 50	Ani	napolish	102144
100	Sta Regist	ate rar	AUG 12	2005 Heren.	& species				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28079 State Registrar 26, per phy, bg, 8/12/05 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2005 04:30 AM Hopkins August 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Eden Wicomico 5225 Cooper Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 X F Yrs. Director 11/08/1903 219-14-2563 101 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic avera "..." 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County Yes 2 □ No Wicomico Salisbury Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 701 Hammond Street 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 none Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Mae Johnson George L. Hoppes, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 92 Tatoosh Place, Steilacoom, Washington 98388 Cyril G. Hopkins/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) St. Peters U.M. Cem. 08/06/2005 Oriole, Maryland ignature of Funeral S 22. Name and Address of Facility Hinman Funeral Home ### M00295 11673 Somerset Ave., Princess Anne, MD 21853 Approximate in each line. Part i. Enter me the s shock, or heart failure. Approximate Interval Between Onset and Death mediate Cause (Final zhamor's Physician Ossacs e disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 200 uctra 1 ☐ Yes 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy **3**€ No 1 Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home RE NO Hospital: 6X Other (Specify) Caregiver ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA HILE completely filled in by the funeral 28d. Descripe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of De 1 28b. Time of home Certification: Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

State Registrar 29b. Signature/and

Name 3

31. Date filed (Month, Day, Year)

AUG 1 2 2005

eleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Dav. Year)

			For State Registrar	State of M	larylan		rtment of H		nd Menta		2005	28080
	Physici		1. Decedent's Name (First, Middle, La	nst)	HAI	RRÍS	00		Mo	te of Death	Day Year 3 200	3. Time of Death 5 0843 M
	/Medic Examin		4a. Facility Name (If not institution, gire	re street and number		7.712	4b. City, Town, or	Location of			4c. County of Dea	
1	LAdiiii	iei	Chartal Hospia	e at t	he L	alo	Sa	lish	iltu		Will	omico
	Funeral		-			last birthday)	If Under 1 Year	If Under 2		te of Birth	9. Bi	rthplace (State or Foreign
	Director		213-14-7901	1 <b>X</b> M 2□F	86	Yrs.	Months Days	Hours	04-	te of Birth onth, Day, Y	19 Vir	ountry) g <b>i</b> nia
	P J		Usual Residence of Decedent  10a. State 10b. County		100 00	y, Town or Lo						101 take Objections
	anyia shov	_	10a. State 10b. County									10d. Inside City Limits 1 Yes 2 □ No
	the Marylar 28a-f show	ecto	MD Worcest  10e. Street and Number	er	P	ocomok				100	Citizen of lether O	
	with t	ā					10f. Zip Code			Tog	Citizen of What C	ountry?
	s 23	eral	8 Somerset Aver	12. Was Deceder	t Ever in U	S 13 V	21851		in? (Specify Y	es or No-	USA 14. Race - Am	erican Indian
10	fter d	by Funeral Director	1 Never Married 2 Married	Armed Forces	?	H	Vas Decedent of Hi Yes, specify Cuba	n, Mexican,	Puerto Rican,	etc.)	Black, Whi	
936	urs a		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1	Yes 2 No	Specify:			Specify:	Thite
21215-0036	within 72 hours after death with the Maryland ane. then 'natural', or Items 23a or 28a-f show Ite Madical Ezamher must be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Deced	ent's Usual Occupa	ation	of working	16	b. Kind of Business	s/Industry
21	thin 'e	npie	Elementary/Secondary (0-12)	College (1-4o	5+)	iife. L	O NOT use retired	)	or working			
	filed wi Hygien Sther th	So	8	none		Butcl	ner					Store
pu	tal Hy d oth	Be	17. Father's Name (First, Middle, Las	")							iden Surname)	
yla	should nd Men marke umatic	2	Edgar Harrison						rite Ha			
Maryland	12 sh h and 7 Is m Iraum		19a. Informant's Name/Relationship Arethia Harrison								City or Town, State,	
	1 and Health Sm 27 ther 1	1. 1	20a. Method of Disposition		20b. F	8 Some	erset Ave	Po	comoke Date	City,	MD 21851 c. Location - City o	r Town State
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Madical Examination at any injury or other traumatic event, If a Madical Examination at any injury.		Burial 2 ☐ Cremation 3 [		e   c	emetery, cren	natory or other plac	· 1			•	
Hir	it. Partitude intrant		'4 □Donation 5 □ Other (Spec.  21 Signature of Funera Service Lice	· · · · · · · · · · · · · · · · · · ·	Fir					2005 P	ocomoke C	ity, MD
Ba	permit. Departr Importa any inji	1	MND A NIN	Na. O			Name and Addres					
	n 15 - 65		23a. Part 1. Enler the lisease, or con	nplications that cause	-MOO2	95 1 1	1673 Some or the mode of dvin	rset .	Ave., I	rince	ss Anne,	Approximate
		4	3a. Part1. En er the Isease, or conshock, or heart failure. List only Immediate Cause (Final	one cause of each	line.	2	1		16	/	-	Interval Between Onset and Beeth
	Physician /Medical		disease or condition resulting in death)	a Due to (or a	T/L (	wence off:	d luno	0	7 (6/	071		6 months
B	Examiner	П		•	3 4 0011304	derice orj.						
		ē	Sequentially list conditions, if any, leading to him collect cause. Enter Underlying Cause (Disease or injury	b. Qualto (or s	s a consuq	sence of):						
	d d ansit	Examiner	Cause (Disease or injury that initiated events	C								
oʻ	be executed sician and burial-transit	Exe	resulting in death) Last	Due to (or a	s a conseq	uence of):						
8760	death certificate be executed e attending physician and of for use as the burial-transi	dicai		d								
9	ng ph as t	Med	IF FEMALE:								7	
Вох	seath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Feta	Ideath 3	Ectopic pregnancy				23d. Date of de Month	elivery Day Year
0.		sici	1 Yes 2 No	4□Pregnant 9□Unknown		eath 5□	Other (specify)				i i i i i i i i i i i i i i i i i i i	Day 10a1
Ρ.	that the death ed by the atte detached for	Phy	Part II. Other significant conditions	contributing to death	hut not res	ulting in the ur	idertyjna cause givi	en in Part I	2:	3e Did toba	cco use contribute t	to the cause of death?
Records,	es De de	l by	Tarris official series	oon in grand and in	541714170	anny m trio di	iddiny ing daddo givi	377 1177 01771		1 ☐ Yes	1	robably 4 Unknown
or		etec								. 146	1	
3ec	B 25 C	Completed								4a. Was an autopsy performe	prior to	completion of cause of
a	iician: The lav certificate has rector, page 2									☐Yes 2	No 1 □ Ye	
Vital	ding Physician: The the the the this certificate hatfuneral director, page	o Be	25. Was case referred to medical examiner?	Hospital:			Oth	or	of Death (Che			
ō	Phy ral di	h	1 Yes No	28a, Dite of In	iurv	ER/Outpatien 28b. Time of	28c. Injury	4 L Nur	-		ce 6 Other (Spe	ecity)
on	ding th. Afte fune	tion	Natural 5 Pending investigation	(Month, E	lay Year)	Injury	Worl	k? Yes 2⊟N	ło			
Division	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not	28e. Place of I	njury - At h	ome, farm, stre	eet, factory, office					Rural Route Number,
á	al or s afte	Certification;	4  Homicide	building,	etc. (Specif	Y)			Ci	ty or Town, S	State)	
	To the Hospital or Attend within 24 hours after deati To the Funeral Director: completely filled in by the	Medical C	29a. Certifier Certifying P	hysician: To the besing	of examina	owledge, death tion and/or inv	occurred at the timestigation, in my of	ne, date and pinion, deatl	d place, and du h occurred at t	e to the caus he time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	₩ We	29b Signature and title of certifier	///	7/	. N	29c. License	number		29d	. Date signed (Mon	th, Day, Year)
	. , , ,	<	1000	16	// V	W)	100	262	78		8-3.	-05
			30. Name and address of person who	completed cause of	death (Item	n 23a) (Type,	Print)	13-	> /	7 7		
_			DAVIDE. COUALL, 1	ND COAST	AL H	DSPILE	Print) P.O. BU	x113	5 5	olish	MO	21802
	Sta Regist		31. Date filed (Month, Day, Year)		Mar's Signa		have.			(	$\bigcirc$	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 28081 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Agnes Pearl Hamilton August 11, 2005 6:40 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Long View Nursing Home Carroll Manchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 12, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🔀 F Director 215-09-7107 94 Yrs Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show Items 23a or 28e-f show 1 Yes 2 No Director Carroll Manchester Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3237 Grafton Street 21102 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. the Medical Examiner: 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2√ No Specify: Specify: by white 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any july or other treumatic event sons. Be William Ruby Martha Boyen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley I. Hamilton, son 3237 Grafton Street, Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Carroll Cremations 08/13/2005 1 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 21. Signature of Funeral Service Licensee M00723 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ney monia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause is leaded or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Demention 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed lardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 Voluming Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) After the funeral 27. Manger of De th 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MSL 0/2901 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Deogracias Faustino MD, 4111 L. Beckleysville Road, Hampstead, MD 21074 32. Recentrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 2 2005 Registrar

			1 - For State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artment of H	lealth a Death	and Me	ntal Hyg	giene	005	28082
			1. Decedent's Name (First, Middle	, Last)		-			2	. Date of Dea	ath Day	Vons	3. Time of Death
ı	Physici /Medic		James Edward	Inman					A	ugust		.005	5:45A M
	Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, or		of Death		4c. Co	ounty of Death	
			Casey House				Rockvill					tgomer	
	Funeral Director		5. Social Security Number 416–46–6018	6. Sex 1 XM 2 ☐ F	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. N	Date of Birth (Month, Day 0V 25,	1936	9. Birth Cou Alab	olace (State or Foreign ntry) ama
	land		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mary -feh	ţŏ	Maryland Montgo	merv	Silv	ver Sp:	rino						1 ☐ Yes 2 No
	h the	irec	10e. Street and Number				10f. Zip Code				10g. Citizer	of What Cou	ntry?
	23e c	a	334 Mississippi	Avenue			20910				USA		
36	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Items 23e or 28e-f ehow ent. The Modical Examiner mast be motified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced	Armed Fo	edent Ever in U. orces? 2 \( \text{No}\) ve oates \( \frac{1}{2} \)		Was Decedent of H If Yes, specify Cuba 1□Yes 2XNo	ispanic Ori an, Mexicar Specify:	n, Puerto Ri	fy Yes or No- can, etc.)		Race - Ameri Black, White, Pecify: Whi	etc.
21215-0036	2 hou	ted t	15. Decedent	's Education	74(034)31	16a. Dece	dent's Usual Occup	ation				of Business/In	
215	hin 73	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (	1-4or 5+)	(Give	kind of work done on DO NOT use retired	during mosi 1)	t of working	'			,
	ed wit	Con	9			Busi	ness Owne				Vendi		
nd	tal Hydral Hydrau	Be	17. Father's Name (First, Middle,	,						First, Middle,		,	
З	ould 3 Men narke netic	<sup>o</sup> L	John Benjamin Ir							le Har			
, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then. Insturel; or Items 23e or 28e-f ehow ampringers if Item 27 is marked other then. Insturel; or Items 23e or 28e-f ehow ampringery or other treumetic event, the Marical Examiner must be notified at ODGe.			Deale Chu	Itess (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1e Churchton Rd. Churchton, MD 20733								
Baltimore,													
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service	cicensée Ha	MO12	251 R	Name and Address Oing Home	ss of Facilit Crem	ation	Servi	ce P	.0. Box	x 784 e, MD 21029
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	caused the deat	h. Do not ent	er the mode of dyin	g, such as	cardiac or r	espiratory ari	rest,	KSVIII	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		static I	lung C:	ancer						Onset and Death
	/Medical Examiner		resulting in death)	w	(or as a conseq		AIICCI						
П	Cxammer		Sequentially list conditions,	b	,								
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):							
_6	nxecul n and al-trar	Examiner	that initiated events resulting in death) Last	c	(or as a conseq	uence of):							
8760,	cate be executed physician and the burial-transit	dical		L <sub>d</sub>									
.89	ifficate g phy as the	edic		u.									
.O. Box	that the death certifi ed by the attending I detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live t	tcome of pregna pirth 2 Feta nant at time of do own	Ideath 3[	Ectopic pregnancy Other (specify)			<del></del>	23d	. Date of delive Month	ery Day Year
Δ.	es that thighed by be detac	/ Ph	Part II. Other significant condition	ns contributing to d	leath but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use	contribute to ti	ne cause of death?
ords,	aquir en s	ted by								1 🗆 Y	es 2 N	lo 3X Prot	pably 4 Unknown
Record	The law ate has b page 2 sl	Completed							_	24a. Was a autops perfor	sy		psy findings available mpletion of cause of 2 No
Vital	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	11					of Death (	Check only or	16)		
of	dir d	2	1 Yes 2 X No			ER/Outpatien		4 🔲 IVU					hospice
	ding After fune	lon	1 XNatural 5 ☐ Pendin	9	th, Day Year)	28b. Time of Injury	Work	γατ k? Yes 2.∐I		d. Describe h	ow injury of	ccurred	
Division		ficat	2 Accident investig 3 Suicide 6 Could r	not be 390 Pinos	of Injury - At ho	ome, farm, str	eet, factory, office	103 2		Location (S	treet and N	umber or Rura	I Route Number,
27. Manner of Death 1 X Natural 2   Accident   3   Suicide   4   Homicide   4   H								City or Tow	n, State)				
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	To the within 2 To the complet	Ž	29b. Signature and title sortilion	MIII,	ノ,		29c. License	number		2	9d. Date si	igned (Month,	Day, Year)
ſſ	+6		CERCE,				1441	218			81:	12/C	75
C	€.6		30. Name and address of person	who completed caus	0 -60	01 M	UNCASI	K-1	Mille	ed k	ock	ville.	MD 20855
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1	5 2005	gistrar's Signa	ture	berli			-/-			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. C.

			1 - State Amend Item 23	a per me G84	7 9-12-6	tificate of	Death	Re	g. No.	28083
	Physici	an	Decedent's Name (First, Middle, Last	")				2. Date of Death Month	Day Your	3. Time of Death
	/Medio		Ronald Timothy 4a. Facility Name (If not institution, give	Johnson				AUGUST	10, 2005	2:46 P M
	Examir	ier	4a. Facility Name (If not institution, give CALVERT MEMORIAL				r Location of Death FREDERICE	ζ	4c. County of Death CALVERT C	)
	Funeral		Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Births	place (State or Foreign
	Director		217-68-6172 Usual Residence of Decedent	XM 2□F 4	8 Yrs.	Widthlis Days	Hours Will.	11/17/1		VA
	yland		10a. State 10b. County	100	. City, Town or Lo	cation			1	0d. Inside City Limits
	e Mar	ctor	MD Prince G	eorge's		Bra	ndywine			1√ Yes 2□No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?
	ath w	rai	13204 Crain Hig			206			USA	
	er de Item	E S	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☆ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2∏ No	Specify:		Specify: Wh	ite
5-0	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	ient's Usual Occup	ation during most of work	ina 1	6b. Kind of Business/In-	
121	within ne.	mp.	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work 1)			
d 21	filed with Hygiene, other thai		12 17. Father's Name (First, Middle, Last)		Gas	Station	Manage 18. Mother's Name		Retail Sa	les
au	ould be Mental mrked o	To Be		. John						
Maryland	2 should and Men is marken	-	Aubrey Williar 19a. Informant's Name/Relationship (7)		19b. Mailir	g Address (Street	MIIMA and Number or Run	Genevi	eve Johns City or Town, State, Zip	On Code)
	1 and 2 Health a tam 27 Is		Carolyn Johnson 20a. Method of Disposition	/Wife	1320	4 Crain	Highway	z. Branc	dywine, M	D_20613
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		b. Place of Dispo cemetery, crem	sition (Name of natory or other plac	(e)	pafe 2	Oc. Location - City or To	wn, State
I iii	permit. Page Department of Important: If any Injury or phos.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euperal Service Licens		o. Memo	rial Gd . Name and Addre	Dunkirk,	MD		
Ba	Depa Impo any I		Wood F.H.	ood F.H., P.A. 20754						
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the	iv ber tens	BOX 43	O, Dunk Ovascara	Trk, MD	e complicat	Approximate Potygon
	Physician		Immediate Cause (Final disease or condition	+ Lake	t Ephedi	ine use	1		Care	Onset and Death
	/Medical Examiner		resulting in death)	Due to for as a cor			0100	0.0		
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ő,	e execten ar		resulting in death) Last	Due to (or as a con	sequence of):					
68760,	rificate be executed ng physicien and as the burial-transit	Aedical		d						
9 X	i po e	/Me	IF FEMALE:	3c. If yes, outcome of pre	agnancy					
Box	death cert e attendin id for use	Iclar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ F 4 Pregnant at time	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
P.O.	that the de led by the a detached i	Physician/A	9 Unknown	9□ Unknown						
	9 P P	Ď	Part II. Other significant conditions con	ntnbuting to death but not	resulting in the ur	derlying cause give	en in Part I.		acco use contribute to the	
Records,	w requir been s should	Completed								ably 4 □Unknown
Rec	The law ete has page 2 s	dm						24a. Was an autopsy performe	24b. Were autop prior to con death?	osy findings available apletion of cause of
		ပိ	25. Was case referred to medical				26. Place of Death	Yes 2	□ No 10 Yes	2□ No
of Vital	0 v 0	To B	examiner?	lospital:	VZV R/Outpatien	3 DOA Othe	ar.	ACTION TO A STATE OF THE STATE	ce 6 Other (Specify	<b>(</b> )
	ding Ph th. After thi funeral		27. Manner of Death	28a Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injun Work		28d. Describe how		/
sio	Attending r death. ector: After by the fune	catle	Accident investigation			M 1 🗆	res 2 □No			
27. Manner of Death   State   State						:	28f. Location (Stre City or Town,	et and Number or Rura. State)	l Route Number,	
Accident   3   Suicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and City or Town, State)   29a. Certifier   29a. Certifier   29b. Signafure and tyle of certifier   29c. License number   29c. License number   29d. Date						ise(s) and manner as st e and place, and due to	ated. the cause(s)			
	To the within To the	Me	29b. Signature and tyle of certifier			29c. License	number	290	d. Date signed (Month, L	Day, Year)
)			I lorke a	(U)		0 (	СМЕ	I	AUGUST 11,	2005
	4	d	30 Name and address of person who co	ompleted cause of death (	Item 23a) (Type, I	יירות) 11 ס זאדאים מ	STOPET D	АТ ТТМОВЕ	MADVI AND	21201
		Y	31. Date filed (Month, Day, Year)	32. Registras Si	anatura		OIKEEL, B	HULLINOKE,	, MARYLAND,	21201
	Sta , Registra		ALIG 1	32. Registras S	grature K	boutes				

State of Maryland / Department of Health and Mental Hygiene Amend Item 8 per FH, G852 03/92/06 dbb eath 1 - For State Registrar 28084 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Vivian E. Jones August 10, 2005 9:00 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 534 Jefferson Pike Knoxville Frederick ff Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10/10/1935 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 232-54-3083 69 West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s constant any injury or other traumatic 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Directo Frederick Knoxville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 534 Jefferson Pike 21758 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ Specify: 3 Widowed 4 Dorvorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Elementary/Secondary (0-12) College (1-4or 5+) Social Services caregiver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bun Toms Georiga Dunson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Soares - daughter Buffington Road, Woodsboro, Maryland 21798 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial 8-14-2005 Frederick, Maryland 21. Signature of Funeral Service Likensee 22. Name and Address of Facility Stauffer Funeral Home Sharon 1100 N. Maple Avenue, Brunswick, Maryland 21716 Carulle alive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ama rehr /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a ansequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical lhe IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 I ive birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation м 1 Yes 2 No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 166/8 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet righter RUNSWICK JAYNE egistrar's Signature 31. Date filed (Month, Pay, Year) AUG 15 2005 State Registrar

		1 - For State Registrar	State of Marylar		artment of I		d Mental Hy	Reg. N	2005	
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las     JULIDA KILAFWA     A. Facility Name (If not institution, give	KUN street and number)		4b. City, Town,		AUGth	1 0 Day	2005 County of Dea	
Funeral Director		213-23-1000				If Under 24 l	Hrs. 8. Date of B		9. Bi	MERY  rthplace (State or Foreign ountry)  MICRONESIA
e Maryland Be-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD MONTGC		ty, Town or Lo	TOWN					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
s 23e or 2	Funeral Director	10e. Street and Number 20182 CLUB HII	L DRIVE	18 112	10f. Zip Code 20874		2 (Specify Yes or N		usa of What C Usa 14. Race - Am	
ours after de rel', or Item	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cut		? (Specify Yes or Nuerto Rican, etc.)	1	Black, Wh	
ine, what yearlied 2.12.15.0000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the and the marked other then "naturel", or Items 23e or 28e-f show then 27 is marked other then "naturel", or Items 23e or 28e-f show other treumetic event. The Medical Express.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire NISTRAT	during most of			nd of Business	s/Industry SYSTEM
should be filed within nd Mental Hygiene.	To Be C	17. Father's Name (First, Middle, Last) TULENSRU KILAF		105 84011	an Addansa (Sana	SEPE	Name (First, Middle TILFAS r Rural Route Num	3		7in Code
Tand 2 shows the street of the		19a. Informant's Name/Relationship (Tarthy MICHAELIA	N / FRIEND	119		AVE.,	ROCKVII	LE,		0850
partition Pages 1 Department of H Importent: If ite any injury or ot		20a. Method of Disposition  1	Removal from State  FRE	cemetery, cre	matory or other place CREMA	TORY	/15/05	1	DERIC	
permit Depart Import any in		21. Signature of Fundial Service Licen	1	H	2. Name and Addr ILLTON E 2.O. BOX	UNERÁI 86, E	BARNESVI	LLE,	MD	20838
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only: Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. ACUTE LYME  Due to (or as a consect  Due to	PHOBLA quence of):				arrest,		Approximate Interval Between Onset and Death
box corficate be executed feath certificate be executed a strending physician and for use as the burial-transit	edical	IF FEMALE: 23b. Was decedent pregnant	d	nancy				23d. Date of delivery		
the death by the atter ached for u	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown		□Ectopic pregnand □ Other (specify)	5y			Month	Day Year
wrequires that the death been signed by the atte	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	underlying cause g	iven in Part I.		tobacco u Yes 2		to the cause of death?  Probably 4 Vunknown
The lay	Completed	Of Manager referred to medical				DG Place of	per 1 🗆 Yes	opsy formed? 2 A No	24b. Were a prior to death?	autopsy findings available completion of cause of s 2 \sumbed No
la sign	To B	25. Was case referred to medical examiner?  1  Yes 2 No						sidence 6	ce 6 □Other (Specify) injury occurred	
To the Hospitel or Attending Proving the Within 24 hours after death. To the Funerel Director: After it completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and City or Town, State)							d Number or F )	Rural Route Number,
ne Hospi n 24 hou ae Funer bletely fill	edical		ysician: To the best of my kn niner: On the basis of examin and manner stated.							
To this	M	29b. Signature and title of certifier  30. Name and address of person who	completed cause of death (lite	om 23a) (Type	D	516	b		e signed <i>(Mor</i>	nth, Day, Year) 2005
. Sta	ate	NELSON KALIL,  31. Date filed (MAN) (Par) Year 200	MD 18111 E		PHILIE	DR.,	OLNEY,	MD	20832	

State of Maryland / Department of Health and Mental Hygien 200528086 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9, DIANNE MARIE KELLY AUGUST 2005 12:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2525 BALTIMORE BLVD. #10 FINKSBURG CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□ M 2□XF Months 47 Director 212-80-4737 1957 NEW YORK Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show ed other then "neturel", or items 23e or 28e-f shore event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Completed by Funeral Director CATONSVILLE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 WYNDCREST AVE., APT. 21228 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after innent of Health and Mental Hygiene. ant: If item 27 is marked other then "neturel", or itel ☐Yes 2MNo f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 REGISTERED NURSE HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDWARD JAMES KELLY PATRICIA ANNE FINNERAN 2 treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21048 PATRICIA A. KELLY - MOTHER 2525 BALTIMORE BLVD., item 27 other tre #10 FINKSBURG, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 又 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Importent: If any injury or once. CARROLL CREMATION AUG. 10, 2005 HAMPSTEAD, MD 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.
O.1 WILLIS ST. WESTMINSTER, MD 21. Sanature of Funeral Service Licensee M01191 Currolle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lip. Approximate Interval Betwee Onset and Dea Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): the burialattending physician a for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Ther (Specify) examiner HOME Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 Yes ZIN No a 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural Injury 5 Pending 1 🗌 Yes hours after death. 2 Accident investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 29a. Certifie Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check or one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, 29b. Signature and WSL address of person who so Name 1KS1 31. Date filed (Month, Day, Year) State AUG 1 Registrar

# **VOID**

# CERTIFICATE #

2005-28087

# SEE

**CERTIFICATE #** 

04-43138

State of Maryland / Department of Health and Mental Hygienes A

			1 - State Registrar	State of Marytar	iu / D	Certif	ficate of l	Death		gierie Rag. No.		28088
	Physicia	an	Decedent's Name (First, Middle, La.  Wayne Jose	eph LeBlanc					2. Date of De Month August		2005 Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv			41	b. City, Town, or	Location of Death	August	_	County of Death	11:00 P M
			4 B Street				Loth				Anne Aru	
	Funeral Director		5. Social Security Number 6. S 213–56–3099	ex 7. Age (In yrs. 54			f Under 1 Year lonths Days	Hours Min.	8. Date of Bird (Month, Da Sep 12			place (State or Foreign htry)  hington, DC
	land		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town	or Locati	ion					0d. Inside City Limits
	Ba-f sh	ctor	MD Anne Ar	ındel L	othi							1 ☐ Yes 2 🛣 No
	th with th	Funeral Director	10e. Street and Number 4 B Street				10f. Zip Code <b>2071</b>	1		10g. Citi	izen of What Cour USA	ntry?
250	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hylgiene. Department of Health and Mental Hylgiene. Important: If time 72 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Meulcal Examinar months notified at once.	by	11. Marital Status == 1	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 및 No If Yes, Give Year or Dates:	J.S.		s Decedent of H es, specify Cuba Yes 2∰ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: W	
5	n 72 ho natur	Completed	15. Decedent's E (Specify only highest gra	ducation ide completed)	16a. l	Decedent	t's Usual Occupa d of work done	ation during most of work	ing		nd of Business/Ind	
7 7	withir liene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)			inter	)		•	Construc	
2	al Hyg d othe	BeC	17. Father's Name (First, Middle, Last					18. Mother's Nam	e (First, Middle,	Maiden	Sumame)	
yia	d Ment d Ment narked natic	Lo	Joseph		lanc		111 (2)	Gladys	78	0.11		mpson
2	nd 2 st alth and 27 ie n r traun		19a. Informant's Name/Relationship ( Sonja Page (s:	ister)	4		Street	and Number or Run Lothia		or, City o 2071		Code)
์ เ	Pages 1 a nent of Hea int: if item iry or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  Other (Specif	Removal from State	cemetery	v, cremato	on (Name of ory or other place atory	1	11 005		ocation - City or To	
	permit. Departir Importa any inju		21. Signature of Juneral Service Licer	e Coff		22. N	ame and Addres	ern Mary	Funera	l Ho	ome Calve	ert, PA
	Physician /Medical Examiner		23a. Pan1. Enter the disease, o com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	50	ot enter the	he mode of dyin	<del>-</del>	or respiratory ai	rest,		MD 20736 Approximate Interval Between Onset and Death
	sit	iner	Sequentially list conditions, if any, loading to him ediato cause. Enter Underlying Cause (Disease or injury	b. Cua to (or as a nonsec	puennei ci	6)-						
,00	rificate be executed ng physicien and as the burial-transit	ai Examiner	that initiated events resulting in death) Last	C. Due to (or as a consec	dneuce o	t):						
00	rlificate ng phy as the	Medicai	IS SECOND S	_ d								
0	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death		topic pregnancy ther (specify)			4	23d. Date of delive Month	Day Year
cords, r.	w requires that t been signed by should be deta	by	Part II. Other significant conditions of Cevebral L	contributing to death but not res				en in Part I.				ne cause of death?
משבע	The law re ate has bee page 2 sho	Completed	Seizure	DISONde					24a. Was autor perfo 1 \( \text{Yes} \)	sy rmed?	24b. Were autoprior to condeath?	psy findings available inpletion of cause of
\ \ \	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	7-5-1-		Oth	26. Place of Deat				
20 21	ding Physicien: The t n. After this certificate ha funeral director, page	ion: To	12 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Ti	ime of ijury	28c. Injun World		ome 5 2 Resident			ν)
DIVISION	Attenor deat	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e Goo Gloss of Injury. At h	nome, far			Yes 2 □No	28f. Location (S City or Tox	Street an vn, State	d Number or Rura )	l Route Number,
	To the Hospital or within 24 hours after to the Funerel Discompletely filled in	Medical C	29a. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Certifying Ph 2 Medical Exam	nysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, ation and	, death oc Vor invest	curred at the tin tigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifler	De De	p EL	ty	29c. Licens				e signed (Month,	
			30. Name and address of person who	completed cause of death (item	m 23a) (		(090	- Am	erin B	<u></u>	1. 211	735
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 1	32. Registrary Sign	ature		books	Jive				

State of Maryland / Department of Health and Mental Hygien  $\geq 0.05$ 28089 State Registranmend item #1 per phy g846 8 Periffication of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Timothy McLoughin TIMOTHY J. McLOUGHLIN  $P^{M}$ 8 14 2005 4:57 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/29/1934 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□F Months Yrs. 70 Director 081-26-2774 Usual Residence of Decedent 10c. City. Town or Location 10a State 10h. County 10d. Inside City Limits 7 is marked other than "neturel", or items 23s or 28e-f show treumatic event, the Modical Examinar must be notified at 1 ¥ Yes 2 ☐ No Directo Congers NY Rockland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 35 Westview Ave. 10920 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1958-64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Co-owner Home Health Care 12 should be filed w h and Mental Hygien 7 Is marked other th 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel McLoughin 2 Delia Cleary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Item 27 35 Westview Ave., Rockland, NY 10920 Patricia McLoughin/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importent: If It le eny injury or o **☆** Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Gethsemane Cemetery 8/17/2005 Rockland Lake, NY 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 23a Part 1. Enter the disease, or complications that caused to death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List daily one cause on each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death mmediate Cause (Final Physician MYDCARDIAL INFARCTION FEW PURMITES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EN YEARS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): 68760, The law requires that the death certificate be Physician/Medical 10 00 P/ IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1/29/19 Records 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown MONTH Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 KNo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ► P/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Division ( or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 106240 Holeworth 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17 9+1 203 M.D ZINCKIH egistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2005 Registrar

hlin

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registral 28090 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year JEAN E. MYERS 13:48 M AUGUST 9 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Hours 1 ☐ M 2 🗷 F Director 217-36-7778 Yrs 66 Dec. 10 1938 Washington, D.C. Usual Residence of Decedent the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show njury or other traumatic evant, the Musical Examiner must be notified at Md. Director Montgomery Clarksburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 24015 Stringtown Road 20871 or Itams 23a United States death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3. Widowed 4 □ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "na any Injury or other traumatic evan" once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Head Start Aide 0 County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl David Burroughs Elizabeth Reese ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2626 Braddock Road, Albert E. Myers / Son Mt. Airy, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/05 1 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery Rockville, Md. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee W-Barker P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HYPOXIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit TOBACCO ABUSE resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe Chronic Bronchitis Rhinitis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hard of Hearing 24a. Was an cate has autopsy performed' certificate 2 No 2□ No Division of Vital 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 701 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C D0056132 August 10, 2005 in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Olney-Laytonsville Road, Olney, Md. 20832 Narita Surana, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Physicia /Medic Examine	
Funeral Director	
D	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 271s marked other then "naturel", or Items 23e or 28a-f show eny injury or other traumatic event, the Medical Examinating to notified at earth and marked of other promited at earth and marked at earth a

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

al er	Decedent's Name (First, Middle, Last)     ELIZAB	eth te	RESA MO	RRISON	2. Date of I Month Augus		2005	3. Time of Death 3:00 A	
	4a. Facility Name (If not institution, give street and number, Lorien Taneytown	)	,	r, Town, or Location of Dealeytown		4c.	County of Death		
	214-32-4551 1 M 20XF	ge (In yrs. last b 79		er 1 Year   If Under 24 Hrs Days   Hours   Min	. (Month,	Birth Bay, Year) 5, 19:	9. Birth Cou 25 Mary	place (State or Fore intry) and	
	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Lin	
to	Maryland Carroll	Tan	neytown					Y∏Yes 2□	
al Directo	10e. Street and Number 39 Middle Street			ip Code 787			10g. Citizen of What Country? United States		
by Funerai	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forces 1 Pes 2 Married 17 Yes, Give Year or Dates:	? No	If Yes, spe	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2X No Specify:	Specify Yes or to Rican, etc.)		14. Race - Ameri Black, White Specify: Whi	, etc.	
Completed	15. Decedent's Education (Specify only highest grade completed)	16	Sa. Decedent's Usi (Give kind of w	ork done during most of wo	orking	16b. Kir	b. Kind of Business/Industry		
mpi	Elementary/Secondary (0-12) College (1-4or	5+) S	iite. DO NOT eamstres	use retired)	garment manufacture				
Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Na		lle, Maiden	Sumame)		
10	Bernard Francis Morrison  19a. Informant's Name/Relationship (Type, Print)			ss (Street and Number or R		nber, City or	r Town, State, Zi		
	Barbara Wantz / niece		146 Harne	_	-		a. 17340		
	20a. Method of Disposition  1 🖫 Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	l cemet	of Disposition (Na htery, crematory or Joseph's		2005	*	eytown,	own, State Maryland	
	21. Signature of Fureral Service Licensee		22. Name a	and Address of Facility S	ciles Fr	meral	Home		
	23a. Part1. Enter the disease, or complications that cause	<u> </u>		ast Baltimore			ıneytown	, Md. 21	
<u>.</u>	Sequentially list conditions,	s a consequenc							
ai Examiner	if any, leading to immediate  Cause Disease or injury that initiated events  Due to (or a	s a consequenc	ce of):						
Aedicai	if any, leading to immediate  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or a:	s a consequenc	ce of): ce of): ath 3 □Ectopic				23d. Date of delin Month		
by Physician/Medical	if any, leading to immediate  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or a:	s a consequences a consequences a consequences a consequence e of pregnancy 2 Fetal death	ce of):  ce of):  ath 3 □ Ectopic   5 □ Other (s	specify)		d tobacco u	Month use contribute to	very Day Year the cause of death	
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	s a consequences a consequence of pregnancy 2 Fetal death but not resulting	ce of):  ce of):  ath 3 □ Ectopic   5 □ Other (s	specify)	24a. W au pe	d tobacco u	Month  Ise contribute to  No 3 Pro  24b. Were aut prior to cc death?	very Day Year the cause of death bably 4 □Unknoopsy findings avail	
Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	s a consequences a consequence of pregnancy 2 Fetal dea at time of death but not resulting	ce of):  ath 3 Ectopic   5 Other (s	cause given in Part I.	24a. W au pe 1  Yes	d tobacco u  Yes 2[ as an topsy rformed? s 2 No	Month  Ise contribute to  No 3 Pro  24b. Were aut prior to cc death? 1 Yes	the cause of death bably 4 Unknown opsy findings availa ompletion of cause	
To Be Completed by Physician/Medical	Due to (or a series of any, leading to immediate the least of the le	s a consequence s a consequence of pregnancy 2 Fetal dea at time of death but not resulting	ce of):  ath 3   Ectopic    5   Other (s	cause given in Part I.  26. Place of De Other:  4 Nursing	24a. W au pe 1  Yes ath (Check on)	d tobacco u  Yes 2  as an topsy rformed? s 2 No	Month use contribute to No 3 pro 24b. Were aut prior to co death? 1 yes	the cause of death bably 4 Unknoopsy findings avail completion of cause	
To Be Completed by Physician/Medical	Due to (or a start of the property of the pr	s a consequence of pregnancy 2 Fetal death but not resulting tient 2 ER/(ijury ay Year)	ce of):  ath 3   Ectopic   5   Other (s)  g in the underlying  Outpatient 3   D  Time of Injury M	cause given in Part I.  26. Place of De Other: 4 Aurising 28c. Injury at Work? 1   Yes 2   No	24a. W au pe 1  Yes	d tobacco u  Yes 2  as an topsy rformed? s 2 No	Month use contribute to No 3 pro 24b. Were aut prior to co death? 1 yes	the cause of death bably 4 Unknoopsy findings avail completion of cause	
Certification: To Be Completed by Physician/Medical	Due to (or a contributing to death   Due to (or a contributing to (or a contributing to death   Due to (or a contributing to (or a contributing to death   Due to (or a contribution   Due to (or a contri	s a consequence of pregnancy 2 Fetal death but not resulting tient 2 ER/(ijury ay Year)	ce of):  ath 3   Ectopic   5   Other (s	cause given in Part I.  26. Place of De Other: 4 Aurising 28c. Injury at Work? 1   Yes 2   No	24a. W at pe 1   Yes at h (Check on Home 5   Rd. 28d. Describ	d tobacco u  Yes 2[ as an topsy rformed? s 2 No y one) esidence 6 se how injury	Month  Ise contribute to  No 3   Pro  24b. Were aut prior to codeath? 1   Yes  6   Other (Special Contribute of Number of Rur	the cause of death bably 4 Unknown opsy findings availa ompletion of cause	
Certification: To Be Completed by Physician/Medical	Due to (or a contributing to death   Due to (or a contributing to (or a contributing to death   Due to (or a contributing to (or a contributing to death   Due to (or a contribution   Due to (or a contri	e of pregnancy 2 Fetal dea at time of death but not resulting tient 2 ER/C jury ay Year) 28b njury - At home, njury - At home, of examination	ce of):  ath 3   Ectopic   5   Other (s)  g in the underlying  Outpatient 3   D  Time of   Injury M  , farm, street, factor  dge, death occurre	cause given in Part I.  26. Place of De  26. Place of De  27. Injury at  Work?  1 Yes 2 No  28. No  29. Ory, office	24a. W au pe 1 Ye:  Nath (Check on:  Home 5 R. 28d. Describ  28f. Location City or	d tobacco u  Yes 2[ as an topsy informed? s 2 No y one) esidence 6 ee how injury on (Street amore) fown, State,	Month  ise contribute to  No 3 Pro  24b. Were aut prior to co death? 1 Yes  6 Other (Spec. y occurred  d Number or Run )	Day Year the cause of death bably 4 □Unknot opsy findings availa ompletion of cause 2□No ify) ral Route Number,	
To Be Completed by Physician/Medical	Due to (or a start of the past 12 months?   Due to (or a start o	e of pregnancy 2 Fetal dea at time of death but not resulting tient 2 ER/C jury ay Year) 28b njury - At home, njury - At home, of examination	ce of):  ath 3   Ectopic   5   Other (s)  g in the underlying  Outpatient 3   D  Time of Injury  M  , farm, street, factor  dge, death occurre and/or investigation	cause given in Part I.  26. Place of De  26. Place of De  27. Injury at  Work?  1 Yes 2 No  28. No  29. Ory, office	24a. Water per per per per per per per per per p	d tobacco u Yes 2  as an topsy rformed? s 2 No y one) esidence (e) how injun n (Street and rown, State, ne cause(s) le, date and	Month  ise contribute to  No 3 Pro  24b. Were aut prior to co death? 1 Yes  6 Other (Spec. y occurred  d Number or Run )	the cause of death bably 4 Unknown opsy findings avail ompletion of cause 2 UNO  ify)  ral Route Number, stated, to the cause(s)	

,	,		1- State Registrar	of Maryland / D	Department of Ho	ealth and M Death		ene 2005	2 <b>8092</b>
	Physici	an	Decedent's Name (First, Middle, Last)	17			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		Daniel John Mi  4a. Facility Name (If not institution, give street and	ller	4b. City, Town, or	Location of Death	Mugust	19 2005 4c. County of Deatl	
	Examin	er	Union Itospetal of Cec	-, -	EIKto.			Cecil	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	thday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, July 5,		nplace (State or Foreign untry)
	Director		197–36–5339 Usual Residence of Decedent	54	Yrs.		July 5,	1951 Peni	nsýlvania
	yland yow		10a. Sfate 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	B Mar	ctor	Maryland Harford		Aberdeen				Y∏Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23a or 28a-f ahow ampringury or other treumatic event, the Medical Evantian must be inclified at ance.	Funeral Director	10e. Streef and Number 617 Marjorie Lane		10f. Zip Code 2100	1	10	g. Cifizen of What Co U.S.A.	untry?
	ms 23	era	11. Marital Status 12. Was I	Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
9	or Ite	/ Fur	1 Never Married 2 Married 1XX	l Forces? es 2 ☐ No Give	If Yes, specify Cubar  1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, White	
21215-0036	ural',	d by	3 Widowed 4 Divorced Year	or Dates: 19/1-/6				Specify: Wh	
-5	in 72	olete	15. Decedent's Education (Specify only highest grade complet	ed)	Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired)	ition Juring most of workir )	ng 1	6b. Kind of Business/l	Industry
212	d with giene er ther	Completed	Elementary/Secondary (0-12) Colleg	e (1-4or 5+) Ci	vil Service			J.S. Gover	nment
	be filed ital Hygie id other event, th	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Sumame)	
<u>₹</u>	should be and Mental I marked o	٥	John P. Miller, Sr.	10-0			Possiel		
Maryland	id 2 sho lth and l 27 is me treume		19a. Informant's Name/Relationship (Type, Print)  Carol A. Miller (Spo		Mailing Address (Street a 17 Marjorie		erdeen, 1		ip Code) 21001
ē,	of Health Item 27 other tr		20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place	D	-	Oc. Location - City or	Town, State
imo	Pages nent of P ent: If Ite ury or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal fr `4 ☐ Donation 5 ☐ Other (Specify)	om State	Ferris & Co.		)5 We	est Cheste	r, PA
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee	ingleste	Name and Address Tarring—Ca Aberdeen	s of Facility	ral_1800=	359 <sup>A</sup> •	
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death. Do non each line.	not enter the mode of dying	g, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	GULLING YES	spiletory.	Fuilor			Onset and Death
	/Medical Examiner		resulting in death)  Due	fo (or as a consequence of	1	, 0	~		Un
,		er	Sequentially list conditions, if any, leading to immediate	to (or as a consequence of	80000000000000000000000000000000000000	1 1400	4001 a		7065
J	cuted nd. ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.						
90,	cate be executed physician and - the burial-transit	i Ex	resulting in death) Last Due	to (or as a consequence of	of):				
58760,	cate b physic	dicai	d						
Box 6	death certifi e attending I id for use as	n/Me		outcome of pregnancy				23d. Date of deli	verv
	ne death the atte	by Physician/Me	in the past 12 months?	ve birth 2 Fetal death regnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
P.0	ac ac	Phys	3 🗆 Ouknown	nknown					
ds,	Se De es		Part II. Other significant conditions contributing  Eud Sterge 1846	( clipese		in in Part I.	23e. Did toba	acco use contribute to : 2 2 Ne 3 □ Pro	the cause of death?
Records,	- Q 70	letec	Carrier Decide	•	discere		24a. Was an		topsy findings available
Re	The law rate has b page 2 sl	Completed	Distance to 10	7	arrer c		autopsy perform	ed? prior to death?	ompletion of cause of
Vital	sicien: Th certificate rector, pag	0	25. Was case referred to medical	~		26. Place of Death			2 No
of V		To B	examiner? 1 ☐ Yes 2 Ho Hospital:	ДInpatient 2 ☐ ER/Out	tpatient 3 DOA Othe	or: 4 ☐ Nursing Hon	ne 5 Residen	ice 6 Other (Spec	rity)
n o	ing P		1 Anatural 5 ☐ Pending		rime of 28c. Injury		28d. Describe how	v injury occurred	
Division	death ctor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be	lace of Injury - At home, far		res 2 □ No	98f Location (Stre	eet and Number or Ru	ral Route Number
Ρį	al or A s after if Dire	Certification;	4 ☐ Homicide determined b	uilding, etc. (Specify)	, ottoot, lastory, ottoo		City or Town,	State)	Tarrious realization,
	To the Hospital or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Medical O	29a. Certifier 1 ☐ Certifying Physician: To (Check only one) 2 ☐ Medical Exeminer: On the one)	the best of my knowledge ne basis of examination and nanner stated.	death occurred at the time d/or investigation, in my op	e, date and place, a sinion, death occurre	and due to the cau	use(s) and manner as e and place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Month	n, Day, Year)
)	. ~\		· alpy as in m	5	Doos	15190	A	vyost 19	2005
(	10,		30. Name and address of person who completed		(Type, Print)	( , ,	77	~40st 19 ~+, EIK-	
	Sta	tó	31. Date filed (Month provided) = 000= 3	2. A gistrar's Signature	" LIOS COL	1 106	1500 }	T, EIR	Tou ME
	Regist		AUG 2 5 2005	Marin K	Coole				

State of Maryland / Department of Health and Mental Hygien 2005 28093 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2005 CAROLYN MAZUCA HEATHER 9:16 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Upper Chesapeake Medical 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 4/3/1943 Bel Air Harford Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 X F Director 058-34-5499 New York Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Director Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3046 Rocks Road 21084 239 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Completed by White 3 Widowed 4 Divorced netural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 is markad other than "I College (1-4or 5+) Elementary/Secondary (0-12) Paralegal 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ruminski Joseph Dorothy Μ. Bergmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once. Robert L. Mazuza/Husband P.O. Box 151 Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 8/24/2005 Buffalo, New York 4 □ Donation 5 □ Other (Specify) Forest Lawn Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final CANCER 10 METASTATIC Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to minimaliate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coprobute to the cause of death? Records. ð 1 🗀 Yes 2 1 No 3 Probably 4 Unknown page 2 should Be Completed ATREMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Division of Vital tuneral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? ne of Death 28d. Describe how injury occurred Hospitel or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number ause of teath (from 23a) (Type, Print) V 32. egistrar's Signature State 5 2005 Registrar

**ORIGINAL** 

9

3

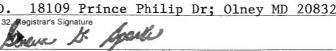
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 28094 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Day 2005 Year August 7, 10:10 P M O'Connor Helen Louise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Ashton 17720 New Hampshire Ave. If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day Year) 1/8/1921 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F 84 Director 220-18-8804 Texas Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ral, or Itams 23a or 28a-f show Exarthermust be notified at Ashton Maryland Montgomery 1 ☐ Yes 2 ☑ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Indepartment of Health and Mental Hygiene and Indepartment if itam 27 is marked other than "natural; or Itams 23e or 2 amy injury or other traumatic avant, the Medical Exacting routing once. 20861 17720 New Hampshire Ave. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Be Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education 5+ Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Klauenberg Martha Clara Heppner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James O'Connor - Husband 17720 New Hampshire Ave; Silver Spring MD 20861 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 8/12/2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Myelin T. Volobert 11800 New Hampshire Ave; Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Mesothelioma Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician a Box 68760. Physician/Medical as esn IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 1 Yes 2 No 1 Yes 2 😾 No Hospita or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death 1 Tes 2 No investigation 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide To the Hospital within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one)

Registra

Dr. Robert Fields M.D. 31. Date filed (Month, Day, Year) 12 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signal fro and title of certifier



29c. License number D34740

29d. Date signed (Month, Day, Year)

8/8/2005

20105 State of Maryland / Department of Health and Mental Hygiene 005

	1-	For State Registrar			Certificate d	f Death	na memanny	Reg. No.	J	200	50
Physician	1.	Decedent's Name (First, Middle, Las Barry		Prout			2. Date of De Month		Year	3. Time of [	Death
/Medical	42	Facility Name (If not institution, give		11040	4b City Tow	n, or Location of	Augus	st 10,2005 132		1320	М
Examiner		Calvert Memori		tal			derick		1ve	rt	
Funeral Director	2	-, ,	7. Age	(In yrs. last birti	hday) If Under 1 Yours. Months Da		Min. 8. Date of Bir (Month, Da	iy. 1°9′64	9. Birthp Coun Mar	lace (State or try) yland	Foreign
land	-	a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City	Limits
Mary B-f she	Ma	ryland Calve	ert		Huntingt	own				1 🗌 Yes	2 <del>X</del> No
uth with the Maryland 23a or 28s-f show ust be rediffed at	3	e.Street and Number 927 Capital Hi	.11 Lane		10f. Zip Coo 2 (	639		10g. Citizen of WI	0g. Citizen of What Country? USA		
		ryland Calve e. Street and Number 927 Capital Hi  . Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify (		in? (Specify Yes or No Puerto Rican, etc.)	9- 14. Race Black Specify:	, White,		
ed within 72 ho ygiene. Par than "natur: t, the Medical is	F	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent's Usual Od (Give kind of work do life. DO NOT use re	cupation ne during most of	of working	16b. Kind of Bus	iness/Ind	dustry	
within iene.		Elementary/Secondary (0-12)	College (1-4or 5+	-)	Brick1a			Mas	onr	v	
s 1 and 2 should be filed within 72 hr fleath and Mental Hygiene. titem 27 Is marked othar than "natu other traumatic avant, the Medical To Be Completed	17	Paul Paul	Prou	t		18. Mother	s Name <i>(First, Middle,</i> lattie		)		
2 should and N is mail		Pa. Informant's Name/Relationship (	• •				or Rural Route Numb				2600
1 and Health em 27 ther tr		ammy Prout/Wif	: е	20b. Place of	27 Capit Disposition (Name of		I Lane	Hunting 20c. Location - C			)639
permit. Pages 1 and 2 Department of Health a Important: If item 27 it any injury or other tra		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	')			Cem. 8	/16/2005	Huntin	gto	wn, MI	
permit Depar Impor any in	21	1. Signature of Funeral Service Licen	einell		22. Name and Ad 1451 De	res be	Sewell.F	uneral rince F	Home	e .,MD20	0678
	23	3a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do n						Approximate Interval Betw	een
Physician	di	nmediate Cause (Final isease or condition esulting in death)	a	OXIA -						Onset and D	eath
/Medical Examiner	1	southly in death)		consequence of		104151	1				
P = E	Se	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury	Due to (or as a	consequence o	il):						
cate be executed physician and the burial-transit	th re	ause (Disease or injury at initiated events sulting in death) Last	C	consequence of			<b>3</b> / <b>V</b>	·			
e be e sician e buria			d								
ing physici	IF.	FEMALE:									-
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transition of the part of the burial-transition of the physician/Medical Examilians.	23	3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death	3 □Ectopic pregn 5 □ Other (specify			23d. Date Mont			ear
uires that the de is signed by the did be detached by the did by Physical	Pa	art II. Other significant conditions o	ontributing to death bu	t not resulting in	the underlying cause	given in Part I.	23e. Did t	tobacco use contrib		ne cause of de ably 4 Dur	
The law requirements that the same set of the	-							psy pr prmed? de	ior to coreath?	psy findings a	vailable use of
iclan: The certificate rector, pag	25	5. Was case referred to medical				26. Place	1 ☐ Yes of Death (Check only of		□Yes	2 No	
the state of		examiner? 1 Yes 2 No	Hospital: Inpatier				sing Home 5 Resi			/)	
ding P. After funera	27	7. Manner of Death  Natural 5 Pending investigation	28a. Date of Injury (Month, Day	Year) 28b. T	njury	njuryat Work? I∐Yes 2∐N		how injury occurre	d		
25. Was case referred to medical examiner?  1   Yes 2   No   Hospital:   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing H    27. Manner of Death   28a. Date of Injury (Month, Day Year)   Injury   28b. Time of Injury   28c. Injury at Work?    28c. Place of Death   28c. Injury at Work?   1   Yes 2   No    27. Manner of Death   28a. Date of Injury (Month, Day Year)   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No    28c. Place of Death   28c. Injury at Work?   1   Yes 2   No    28c. Place of Injury   28c. Injury at Work?   1   Yes 2   No    28c. Place of Injury - At home, farm, street, factory, office   building, etc. (Specify)						28f. Location (Street and Number or Rural Route N City or Town, State)			l Route Numb	er,	
To the Hospital or Attendii within 24 hours after death. To the Funaral Director: A completely filled in by the to	1		ysicien: To the best on niner: On the basis of and manner stat	examination and							
To th within To th compl		Bb. Signature and title of certifier M. Me	638	29d. Date signed (Month, Day, Year) 8/10/05-							
3		D. Name and address of person who Wayantara Mend	onca. M.I	) .	Type, Print) // C	PRINC	PITAL PREZ	ROAD DERICH	#3	206	78
State Registrar	3	1. Date filed (Month, Day, Year)  AUG 1	2 2005 A	Signature	& Speed	E .					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005 28097 State Registrar Amend Item 24a per Dr., G847 (D9/11/24/05dh)Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2005 Jill Μ. Schaeffer August 13 10:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1752 Harvest Drive Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Yrs. Director 55 1949 Pennsylvania 165-38-0177 17, Usual Residence of Decedent illed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehov 77 is marked other than "natural", or itams 23a or 28e-f abov traumetic event, it e Madical Examiner must be notified at 1X Yes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1752 Harvest Drive 21702 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Receptionist Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked other. Be Claude Dennis Geesey Ruth Hershey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael L. Schaeffer/ Husband 1752 Harvest Drive Frederick, Maryland 21702 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State August 15, 2005 Alexandria, Virginia <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the diseast or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition DEMENTIA Physician mu resulting in death) /Medical Due to (or as a consequence of): Examiner DISEASE CNEUTZFELD-JAWB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at I be detached fo 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate Yes 2 1 1 ☐ Yes 2 ₽ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification; To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Pesidence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the within 2. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 31912 ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20015 1564 OPOSS UM ZOUN PILLE MEMOCAL, +D-JULIO 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 005 28098 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Katharyn Mowder August 11, Snyder 2005 3:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10106 Cedar Lane Kensington Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar 22, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F Yrs. Director 441-18-6549 83 1922 0klahoma Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itema 23s or 28s-1 show any injury or other treumstic event, the Modical Exercises marked other treumstic event, the Modical Exercises marked and page. 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2 X No **Funeral Director** Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10106 Cedar Lane 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify:White 1 ☐ Yes 2 ☐XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Mowder Sadie Percifield ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul H. Snyder/husband 10106 Cedar Lane Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 13, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State W. Arundel Crematory 2005 Odenton, Maryland <sup>4</sup> □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Myelodysplatic Syndrome disease or condition resulting in death) 2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Anemia 2 years Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ng physician ar as the burial-to Due to (or as a consequence of): Box 68760, Physician/Medical esn esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Day 4 □ Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s certificate 2 □ No 1 Yes 2 XNo 1 TYes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide 24 hours a 29a. Certifier t X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29b. Signature and the of certified 29c. License number 29d. Date signed (Month, Day, Year) 0 H58874 August 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10400 Connecticut Ave. Suite 606 Kensington, MD 20895 Bradley J. Hunter D.O. 32. Raistrar's Signature 31. Date filed (Month 15 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 28099 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2005 Physician GLORIA ALICE SELF AUGUST 6, 6:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 498 TRACY COURT CARROLL WESTMINSTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
MARCH 9, 1 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 524-56-4775 Director 59 1946 COLORADO Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturat", or items 23a or 28a-f show the Medical Experies must be notified at 10d Inside City Limits MARYLAND CARROLL Director WESTMINSTER 1 ☐ Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 498 TRACY COURT 21157 UNITED STATES filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes XX No þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jiuly or other traumatic event 2008. DORSEY DAVIS ALICE ROWAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN F. SELF/HUSBAND 498 TRACY COURT, WESTMINSTER, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 08/10/2005 XX Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VETERANS CEMETERY OWINGS MILLS, MD 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 91 WILLIS STREET, WESTMINSTER, 23a. Part. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the mode of dying, such as cardiac of respiratory Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) nding physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred Certification: To 1 🗌 Yes completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MI 4

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

State Registrar

KEVIN BREWSTER M.D. 31. Date filed (Month, Day, Year)

ture and title of certif

688C POOLE ROAD, WESTMINSTER, MD 32. Registrar's Signature

2005

e and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

H0055845

29d. Date signed (Month, Day, Year)

21157

28100

1-	For State
	Registra

State of Maryland / Department of Health and Mental Hygien 2005

			State Registrar		Cer	tificate of l	Death	R	eg. No.	•	
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat			3. Time of Death
	Physicia		Arthur Paul Storms			Month Augus					5:00 P M
	/Medic		4a. Facility Name (If not institution, give	e street and number)		4b. City. Town, or	r Location of Death		4c. County of		
Examiner			Holy Cross Hospi				Spring		Montgo		
			5. Social Security Number 6. S		s. last birthday)	If Under 1 Year	1 0	8. Date of Birth	<u> </u>		
	Funeral			DIM 2FIE	90 Yrs.	Months Days	Hours Min.	(Month, Day,			ace (State or Foreign ry)
	Director		Usual Residence of Decedent		90			Feb. 13	, 1915	Indi	ana
and	* ±		10a. State 10b. County	10c. 0	City, Town or Loc	cation				10	d. Inside City Limits
Sa S	# F	ō	California San Be	ernardino	Redland	le					1 ☐ Yes 2 No
de d	28a	Directo	10e. Street and Number	32d2.d2o					10g. Citizen of What Country?		
with	be liled within 72 nouts after death with the Maryland tal Hygiene. Ital Hygiene. do other than "natura", or items 23a or 28a-f show event, the Modical Examinating to motified at		549 Roosevelt Ro		10f. Zip Code 92374			-	iat Count ISA	ry ?	
ath		Funeral									
ar de		une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:			No- 14. Race - American Indian, Black, White, etc.		
S aff	0	by F	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☐ No If Yes, Give	1				Specify: White		
	E H		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							
2 2	"nat	ete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give I	lent's Usual Occupa kind of work done of	durina most of workii	ng	16b. Kind of Busi	.ness/Ind	ustry
<b>7</b> ig	Pan Man	ldπ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	1)				
N 5	Hygier ther th	Completed	12		Bric	k Mason			Steel Ma		cturing
<b>ם</b>	a H	Be	17. Father's Name (First, Middle, Last)	)			18. Mother's Name	(First, Middle, I	Maiden Sumame)	)	
<u>a</u>	Mental arked o	ပ	Elmer Storms				Blanche	Segreta	ain		
Maryland 21215-0036	and Mental is marked c		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	g Address (Street a	and Number or Rura	l Route Number	City or Town, St	tate, Zip (	Code)
<b>S</b> 8	alth 27 i		Margaret E.Storm	ns/ Wife	549	Roosevel	t Road, R	edlands	, CA 923	74	
Baltimore,	ま草部		20a. Method of Disposition		Place of Dispos	sition (Name of natory or other plac	Augi	ate ust 11	20c. Location - C	ity or Tov	vn, State
<b>2</b> 000	ent or y or		1 ☐ Burial 2 ☑ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify			n Cremator			Alexandr	ia	Virginia
	artm ortar injur		21. Signature of Funeral Service Licer		_	-	, ,				
	Department of Health and Menta Important: if item 27 is marked any injury or otter traumatic evonce.			refarles	Fr 50	ancis J.	ss of Facility Collins sity Blvd	Funeral	Home In	c.	MD 20901
			23a. Part1. Enter the disease, or com								Approximate
			shock, or heart failure. List only	one cause on each line.	atti. Do not ente	or the mode or dyni	ig, sucii as cardiac o	i iespiiatory arre	751,		Interval Between Onset and Death
	Again catinity and a secure a secure at the private and the private as the privat	l li	Immediate Cause (Final disease or condition	a Chronic Ob	structi	ive Pulmonary Disease					Years
			resulting in death)	Due to (or as a conse							
		. 1	Sequentially list conditions	b. Conjestive		Failure					Years
70		ner	Sequentially list conditions, if any, leading to infraediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dus to (or as a conse	equanica of):				- 31		
cute		Examiner	Cause (Disease or injury that initiated events	c							
o š	ian a		resulting in death) Last Due to (or as a consequence of):								
X 68/60, certificate be executed	ysic Je br	n/Medical		_ d							
	as th	led									
0 =	endir use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		Ectopic pregnancy			23d. Date	of deliver	y
deat u	e att	100	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)			Month	۱ [	Day Year
<u>ء</u> ج	by the	Physicia	9 □ Unknown	9□ Unknown							
J ig	add b	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the		
<b>Records,</b> he law requires t	: The law requires that the death cate has been signed by the atte page 2 should be detached for	d b						1 ☐ Ye	s 2 🗆 No 3	☐ Proba	bly 4 XUnknown
ក្ត		lete						24a. Was a	24h We	are auton	sy findings available
e e		Completed						autops	y pric	or to com ath?	sy findings available pletion of cause of
									2 🔯 No 1 🗆	Yes 2	2□ No
VITAL	certificate irector, pag	Be	25. Was case referred to medical examiner?	Henritalı		04	26. Place of Death	(Check only on	e)		
Phys	Hospital or Attending Phys 4 hours after death. Funeral Director: After this ely filled in by the funeral dii	2	1 ☐ Yes 2 🛣 No								
		on	27. Manner of Death 1   Natural 5 □ Pending	k?	28d. Describe how injury occurred						
<b>DIVISION</b> i or Attending		cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No  eet, factory, office  28f. Location City or			cation (Street and Number or Rural Route Number, y or Town, State)			
Σ×		Certification:	4 Homicide determined								
בַּיֵּ		Ce									
oso		ca	29a. Certifier 1X Certifying Ph (Check only 2 Medical Exam	nysician: To the best of my kinner: On the basis of examination	nowledge, death	occurred at the tim	ne, date and place, a	and due to the ca	use(s) and mann	ier as sta	ted.
96		Medical	one)	and manner stated.					una piace, ati		
To	within 2 To the I	Σ	29b. Signature and title of certifier	911. il	0	29c. License	e number	25	9d. Date signed (		ay, Year)
	0		1 Mes	100		1)00	01887		8/10/07	_	
ı			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, f	Print)			- / /		
			IMY. MABAN 15	OR FREST GLE.	n RO =	SILVER.	SPRING 1	Mn 209	10		
	Sta	te	31. Date filed (Month, Day, Year)	completed cause of death (Ite  7 FAEST GLE  2005	nature	and the second					
	Registr	ar	AUG 122	2005 Mague.	St. 1830						

State of Maryland /	Department of Health and Mental	Hygiene (	n	
		6 13		2 .

342		1- State of Maryland / Dep	partment of Health and Mertificate of Death			2810	
Physicia /Medica Examine	al	1. Decedent's Name (First, Middle, Last)  Kent E. Schoonmaker  4a. Facility Name (If not institution, give street and number)		2. Date of Death Month Day Yo AUGUST 8, 2005			
	er	ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS	O Date of Righ	ANNE ARUI	NDEL	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 212-70-3543 7. Sex 49 7. Age (In yrs. last birthda 49 7. Age (In	Months Days Hours Min.	8. Date of Birth (Month, Day, ) 4–23–195	Year) 9. Bin 56 Mar	thplace (State or Fore ountry) Yland	
ith the Maryland or 28a-1 show	ector		gewater			10d. Inside City Lim 1 ☐ Yes 2XI	
3a or 2	Dire	10e. Street and Number 3405 Glebe Drive	10f. Zip Code 21037	10	g. Citizen of What Co USA	ountry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Exeminar must be notified at once.	Completed by Funeral Director		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 🛣 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
Baltimore, Maryland 21215-0036 bermit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exernance.	ompleted	(Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) Coltege (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workii DO NOT use retired) truction Worker	ng 16	6b. Kind of Business	ŕ	
/land 2 uld be filed Wental Hygi rrked other utic event, 1	To Be Co	17. Father's Name (First, Middle, Last)  Tracy Bevier Schoonmaker	18. Mother's Name	(First, Middle, Ma	aiden Sumame)	<u>C1011</u>	
Mary		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ing Address (Street and Number or Rura Chickadee Dr., Dun			Zip Code)	
imore, N Pages 1 and nent of Health ant: If item 27 ury or other tr	100000000000000000000000000000000000000	20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State		ate 20	oc. Location - City or Edgewater,		
Balt permit. Deperti import any inj			22. Name and Address of Facility Geo 2973 Solomons Islan	_			
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Approximate Interval Between Onset and Death	
876 ate be hysici	dical Examiner		menia gitis				
P.O. BOX 6. that the death certific ed by the attending p detached for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year	
cords, P	ڄ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 Test 2 No 3 Test 2					
Vital Reco	e Completed	25. Was case referred to medical	00 División (División (Division (Div	24a. Was an autopsy performe	prior to death? No 1 □ Yes	topsy findings available ompletion of cause 2 No	
Of VI	ToB	examiner? 1  Yes 2  No Hospital: 1  Inpatient 2  EF/Outpati				cify)	
Division of Vital Records, i or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be director.	Certification:	27. Manner of Death  1 Natural 5 Pending investigation 3 Suicide 4 Homicide   Death of the determined    28a. Date of Injury    28b. Time of Injury    28b. Time of Injury    28c. Injury at Work?    1 Yes 2 No    28d. Describe how injury occurred    28d. Describe how inj					
_ sassas C	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal (Check only one)	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the cau od at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)	
To the within 2 To the complet	Me	29b. Signature and title of certifier  **Tubricular Ahr**	29c. License number  OCME		1. Date signed (Monti GUST 8, 20		
		30. Name and address of person who completed cause of death (Item 23a) (Type 2ABICUAH AU 111	Print) PENN STREET, BALTII	MORE, MAI	RYLAND, 21	.201	
State Registra	_	31. Date filed (Month, Day, Year)  AUG 1 1 2005  32. Refistrar's Signature	Speeds !				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Day **Physician** Year John Tedder, Wesley Jr. 8:28 PM 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4200 S. Hunter Road Hampstead Carroll If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊊**M 2□ F Director 267-32-6980 May 13, 1927 Florida Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Itam 27 is marked othar than "natural", or Itams 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Event restrict by restlind at Hampstead 1 ☐ Yes 2 ☑ No Director Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4200 S. Hunter Road 21074 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2√ No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wesley Tedder, Sr. Elsie Ellen Holcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Tedder, wife 4200 S. Hunter Road, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State any injury once. \* 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial 08/15/2005 Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M60723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic lung disease or condition resulting in death) Caranoma 5 years /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 4☐Pregnant at time of death Month Year 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No Kenal cell caranoma 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident within 24 hours after death To tha Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Stave WSL B/12/05 D0060503 10.4119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Itmy Staritz, MD 2111 Hanover Pike Mampstead, MD 32. Regitrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Man	yland / Depa <i>Cei</i>	artment of Health and tificate of Death	Mental Hyg	jien 20	05	28103	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	HELEN	Α.	TAYLOR	2. Date of Dea Month	Day	Year	3. Time of Death	
	/Medio		4a. Facility Name (If not institution, give sa			4b. City, Town, or Location of Deat		200 4c. Count	y of Death	2:22 A M	
	LAdimiii	CI	2225 RIDGE RD.			WESTMINSTER	}	CA	RROL	L	
	Funeral		5. Social Security Number 6. Sex		In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth	Year)	9. Birthp	place (State or Foreign	
	Director		213-01-1743	M 2√2 F	94 Yrs.		10/13/	1910		LAND	
	land		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation			1	0d. Inside City Limits	
	Mary Frsh	tor	MD CARROLL		WESTMI	INSTER				1 ☐ Yes 2X No	
	or 288	Director	10e. Street and Number			10f. Zip Code		l0g. Citizen of	What Cour	ntry?	
	23a		2225 RIDGE RD.			21157		USA			
	er de i	Funeral	T. Maria States	2. Was Decedent Eve Armed Forces?		Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ce - Americ ick, White,		
5	rs aft	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No Specify:		Speci	fy: WH]	TE	
9500-612	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ta Madical Exeminer must be notillised at	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupation	4-1	16b. Kind of E			
	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done during most of wo DO NOT use retired)	-				
7		Con	9			HOUSEWIFE		HOME I		₹	
Maryland 2		Be	17. Father's Name (First, Middle, Last)	NIZ T CO	TTTING TO BOTH		me (First, Middle, IA M. W		me)		
Š	s 1 and 2 should be filed f Health and Mental Hygi Item 27 is marked other other traumatic event, I	2	F RA  19a. Informant's Name/Relationship (Typ	NK J. SC		AMELI ng Address (Street and Number or R			<del>.</del>		
	nd 2 s lith an 27 is r trau		FRANCIS C. TAYLO			RABEN WAY, CA			5682		
ē,	s 1 ar		20a. Method of Disposition		20b. Place of Dispo		Date	20c. Location		own, Slate	
altimore,	Pages nent of int: if it iry or o		1 Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	moval from State S	-	ART OF JESUS (		BALTI	MORE	MD.	
<u>a</u>	permit. Pages Department of Important: If it any injury or o		21 Signature of Fureral Service License	9		2. Name and Address of Facility F					
<u> </u>	99 = 9		23a. Part1. Ener the disease, or complic			54 E. MAIN ST.			, MD.	. 21157	
E	Physician /Medical Examiner physician and physician and the print ransit physician and	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last	Due to (or as a c	consequence of):	tie androw	ycely	LIC	ace	yeste	
O. Box 68	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin 9 Unknown	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
יי מי	res that igned b be deta	y Pt	Part II. Other significant conditions con	tributing to death but	not resiliting in the u	ndertying cause given in Part I.	23e. Did to	bacco use cor	tribute to th	ne cause of death?	
ğ	w require been sig should b	ed t	Grone re	val fac	luro		1 □ Y	es 2□No	3 🗀 Prob	pably 4 Unknown	
Records,	ne law re has bee	piet	Jementie				24a. Was a		Were auto	psy findings available impletion of cause of	
	The ate h	Completed by	100 - 1				perfor		death?	2□ No	
Vita	cian: entific actor,	Be	25. Was case referred to medical examiner?				ath (Check only or	ne)			
	Physi this c al dire	ု	1 ☐ Yes 2 No H	ospital: 1   Inpatient	2 ER/Outpatier		Home 5 Resid			y)	
Division of	ding l h. After funer		Natural 5 Pending	28a. Date of Injury (Month, Day Y	/ear) Injury	f 28c. Injury at Work?  M 1 Yes 2 No	200. Describe II	ow injury occu	neu		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of Injury building, etc.	· At home, farm, sti (Specify)		treet and Num n, State)	et and Number or Rural Route Number, State)			
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 2 Medical Examin	ician: To the best of e er: On the basis of ea and manner state	xamination and/or in	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the courred at the time, o	ause(s) and m late and place	anner as si , and due to	tated. o the cause(s)	
	To the within To the comp	ž	29b. gn re and title of pairie			29c. License number	2	9d. Date gn	ed (Month,	Day, Year)	
	WILZ		mundo.	D.D.		H00558	45	8/8/	200	5	
	MILT		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type,	Print HOOF 589		Jan	01	100	
	- ['		JEVIN DEEVS/E 3. Date filed (Month, Day, Year)	7 6886 32. Registrar's	Signature	Fd, WESINI	US/ER	TIP,	211	5/	
di.	Sta Registi		AUG 0 9 2			South ?	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene > 28104 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 Year **Physician** Month August 10, 3:40 Рм Willem J. van der Mei /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 7105 Connecticut Avenue Chevy Chase 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/02/1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 78 Netherlands Director 216-55-3771 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location rai', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Chevy Chase 1X Yes 2 □ No MD Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 Netherlands 7105 Connecticut Avenue Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify White þ 3 Widowed 4 Divorced "natural" in Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financia1 Banker 5+ other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil timent of Health and Mental H tant: If Item 27 is marked oth jury or other traumatic even Be Theunis van der Mei Josephine van Heuven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
important: If Item 27 is
eny injury or other trau Rowheya van der Mei - Wife 7105 Connecticut Avenue, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory08/12/2005 Alexandria, Virginia 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licenses 1040 Rockville Pike, Rockville, Maryland 20852 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line 23a. Part1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic obstructive pulmonary disease Five years /Medical Due to (or as a consequence of) Examiner Sourcially list and lines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) physician a s the burial-Physiclan/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 XYes 2 No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? rector, page 2 s 1 ☐ Yes 2 ☒ No 1 Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral c 27. Manner of Death 1 X Natural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 No Certifying Physician: To the best of my knowledge, danth occurred at the time, date and place, and dua to the date of the Medical 29a. Certifier

State Registrar 31. Date filed (Month, Day, Year) AUG 1 2 2005

Michael a. Westerman, M. D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael A. Westerman, MD, 8600 Old Georgetown Road, Bethesda, Maryland 20814 32 Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760.

Ö

Records. P.

Division of Vital

29c. License number

D52451

29d. Date signed (Month, Day, Year)

August 11, 2005

State of Maryland / Department of Health and Mental Hygien 200528105 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** VANAGS MARGA 2005 3:05 AM 10 /Medical 4c. County of Death 4a. Facility M me (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | New Year | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 X F Yrs. Director 214-34-6664 81 Latvia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28s-f show the Medical Examinar must be notified at 1X Yes 2 No Maryland Montgomery Gaithersburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Chestnut Street, #419 20877 Latvia by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 ie marked other than "natural", or ite 1 Never Married 2 Married ltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Xi Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 Housekeeper Domestic Service Depertment of Health and Mental Hyg Important: If Item 27 is marked other any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ludwig Lange Lena Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Imants Vanags/ Son 13714 Lionel Lane, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State August 2005 12 Parklawn Memorial Park 4 Donation 5 Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc The Marie Parker 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPTICEMIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 48 hours URINARY TRACT INFECTION AND Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 48 hours Hospital or Attanding Physicien: The law requires that the death certificate be executed the burial-transit PNEUMONIA Due to (or as a consequence of): Box 68760. Physician/Medicai led by the ettending p detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ ALZHEIMERS DEMENTA 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 08/10/2005 Doo 6 1937 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Candace Lynn Wilson, M.D. 1501 Forest Glen Road, Silver Spring, MD 20910

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

egistrar's Signature

2005

State of Maryland / Department of Health and Mental Hygien 0528106 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Louise Irene Williams August <sup>1</sup>11, 2005 1155 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV 15 1927 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☑ F 273-22-3319 77 Director Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be flied within 72 hours efter deeth with the Merylend Department of Heelth end Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert Director Solomons 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11750 Asbury Circle 236 20688 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: specify: white δ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Byers H. Beasley Maggie Pearl Beavers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter C. Williams- son 13003 Mills Creek Dr. Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Metropolitan Funeral Service 2005 Alexandria Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee rous 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HYPOXIA. /Medical Due to (or as a consequence of): Examiner ARTERIAL INSOFFICIENCY. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicism and for use as the burief-trensit PHENOMENUN The tew requires that the deeth certificate be executed THROMBO EMBOLIC Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an pege 2 i certificete 1□ Yes 2□ No Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes \2 No this irector: After this by the funerei of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28d. Describe how injury occurred 1 -Natural 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by To the Hospital or A within 24 hours effer To the Funerel Direct completely filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Merdono 111/05 MD D0060638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 HOSPITAL 206-18 ROAD PRINCE FREDERICK HD 31. Date filed (Month, Day, Year) 32. Registras Signature State AUG 1 2 2005 > Glown & Registrar

State of Maryland / Department of Health and Mental Hygien 2005Certificate of Death Reg. No. 2. Date of Death Month 3 Time of Death Decedent's Name (First, Middle, Last) Harris Harold Woods August 9 **Physician** 2005 708A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Memorial Hospital Prince Frederick Calvert Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Months 1**∑**M 2□F 319-20-8312 80 Feb 3 1925 Illinois Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Calvert Lusby Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23s or 11284 Sitting Bull Circle 20657 United States death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. DMYes 2 □ No filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: white Maryland 21215-0036 þ 3
☑ Widowed 4 □ Divorced Year or Dates: 46 - 76"netural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ U.S. Army Colonel 18. Mother's Name (First, Middle, Maiden Sumame) other treumatic event. 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 Is marked oth Helen Olson Raymond Woods 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11284 Sitting Bull Circle Lusby MD 20657 Polly Woods- daughter 20c. Location - City or Town, State Baltimore, 20h Place of Disposition (Name of Aug 9 2005 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Alexandria Virginia 5 permit. Page Department o Important: If any injury or once. Metropolitan Funeral Service \*4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home Rd. Port Republic MD 20676 4405 Broomes Is. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner transit requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ pe Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Alzheimers autopsy has ne dormed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 No Division of Vital Physicien: 26. Place of Death Check on one 25. Was case referred to medical director examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∏ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending After Injury 5 Pending investigation 1 Natural 2 Accident 1 Tyes 2 🗌 No death. after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barth MD HOspital Rd. Prince Frederick MD 20678 Joseph J. 32. Registra 🕏 Signature 31. Date filed (Month, Day, Year) State AUG 1 1 2005 Registrar

) <del>4</del> 2	1		For State Registrar	State of	Marylar		artment tificate				R	g. No.	005		1109
	Physici /Medic		1. Decedent's Name (First, Mide Keith Michael								Date of Dea Month UGUST	Day	Year 005	3. Time of 2222	P M
	Examin		4a. Facility Name (If not instituti 2301 OAK DRIV		oer)		IJAMS	SVIL					ity of Death ERICK		
	Funeral Director		5. Social Security Number 322–60–9097	6. Sex 7.	. Age (In yrs. 38	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. Au	Date of Birth (Month, Day gust 1	<sup>Year)</sup> 1967	9. Birth <i>Cou</i> <b>I111</b>	place (State ontry) nois	or Foreign
	Maryland f ahow	or	Usual Residence of Decedent  10a. State 10b. Coun  Maryland Fred	<sub>ty</sub> erick		ty, Town or Lo								10d. Inside C	ity Limits
	a with the 3a or 28a-	Funeral Director	10e. Street and Number 2301 Oak Drive				10f. Zip	Code	21	754	1	0g. Citizen o		ntry?	
036	72 hours after death with the Maryland "natural", or Itama 23a or 28a-f ahow idical Examinat must be motified at	۾ ا	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Ford arried 1 ☐ Yes 2	1 ☐ Yes 2 ☐ No			Mas Decedent of Hispanic Origin? (Specify Yes or Not Yes, specify Cuban Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☐ No Specify:			fy Yes or No- can, etc.)		ace - Ameri lack, White		
'n	within 72 ho ene. than "natur ha Madical	Completed		ent's Education lest grade completed)  College (1-4)	4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k doné d e retired,	uring most			16b. Kind of	Business/Ir		
Maryland 2	be filed htal Hygi od other avant, I	To Be Co	17. Father's Name (First, Middle  John J.			Lanu I	WVEI	Tec.	18. Mothe	r's Name (	First, Middle,	Maiden Sum			
	and 2 should ealth and Mer n 27 Is marke		19a. Informant's Name/Relation Paula Waldron				-				Route Number				
Baltimore,	L to the to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		1210	Place of Dispo cemetery, crei edericl	natory or ot	ther place		Da:		Frede		own, State Maryl:	and
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	aniele /	Eles	ic, 10	2. Name and <b>521 O</b> <u>r</u>	possi	mtow	n Pik	auffer e, Fre	lerick			21702
ļ.	Physician /Medical		23a. Part I. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	a	ch line.	2016	er the mode	of dying	such as	cardiac or	espiratory arr	est,		Approxima Interval Be Onset and	tween
8760,	Examiner	edical Examiner	saturately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	r as a consec	quence ot):									
.O. Box 6	The law requires that the death centificete be executed the hes been signed by the attending physicien and yage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 □ Fet nt at time of	al death 3	⊒Ectopic pre □ Other (spe						Date of delivery	•	Year
۵.	quires that n signed by uld be deta	٥	Part II. Other significant cond	itions contributing to dea	ath but not re	sulting in the u	ndertying ca	ause give	en in Part I.		23e. Did to			the cause of	
l Records,		Completed							• • • • • • • • • • • • • • • • • • • •		24a. Was a autop: perfor	Sy	o. Were aut prior to co death? 1  Yes	opsy findings ompletion of a	available cause of
Vital	ysician: The is certificete hi director, page	Be	25. Was case referred to medi examiner?					0.5		of Death (	Check only or	θ)			
of	E # #	ion: To	1	28a. Date of	Injury , Day Year)	28b. Time o	1 2	8c. Injury Work	at c?	28	d. Describe h			SCE	NE
Division	Attan er deat ector: by the	Certification:	3 Suicide 6 □ Cou	mined 288. PMC8	of Injury - At I g, etc. (Spec	nome, farm, st.	reet, factory	, office	res A		If. Location (S City or Tow 301		mber or Rui	ral Route Num	nber,
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certification (Check only Medic	ying Physician: To the base all Examiner: On the base and manner	sis of examin	owledge, deat ation and/or in	h occurred vestigation,	at the tim	ne, date an pinion, dea	id place, an	d due to the of	ause(s) and late and plac	manner as e, and due	stated. to the cause(	s)
•	To th within To the	Me	29b. Signative and title of certi	hem	)		290		number CME	1000000	1	9d. Date sig AUGUST		. Day, Year) 2005	
	B		30. Name and address of person	on who completed cause	of death (Ite			STRE	ET, E	BALTIM	ORE, M	ARYLAN	D, 21	201	
	St	ate	31. Date liled (Month, Day, Ye	1 5 200 32. Re	Arar's Sign	ature	Love								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005State Registrar 26, per phy, bg 8/12/05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 4:30AM Windsor 2005 Mary August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 30380 Oak Street Princess Anne Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 F Director 220-03-8102 Maryland 94 11/02/1910 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mentel Hygiene. Intel 17 is marked other than "natural", or items 23a or 28e-1 ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event. The Medical Examinar must be notified at Director Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30380 Oak Street 21853 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Specify. Widowed 4 □ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 none Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James F. Covington Julia F. Waites 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lindsor Windsor/daughter-in-law 4526 Coulbourne Mill Road, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important; If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Andrews Episcopal 08/07/2005 Princess Anne, MD 22. Name and Address of Facility Hinman Funeral HOme Signature In Part Letter the discusse, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate STROXE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner cereby

Examiner

Physician/Medical

þ

Completed

Be

Medical Certification: To

29

P

9 🗌 Unknown

25. Was case referred to medical

1 Yes 2 No

Manner of Death

1/2 Natural

2 Accident

3 Suicide

4 \( \text{Homicide} \)

attending physicien the detached been signed by t should be detach certificate has funera 4 hours after death filled in by

Hospitel or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence d.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death

5 Pending

investigation

6 Could not be determined

Due to (or as a consequence of)	):		

5 Other (specify)

ncy	3 Ectopic preopancy

23d. Date of delivery Day Month

23e. Did tobacco use contribute to the cause of death?

Year

1 Yes 2 □ No

art II. Other significant conditions contributing to death but not resulting in the underlying cause give	n in Pan
art II. Other significant conditions contributing to death but not resulting in the underlying cause give	

28a. Date of Injury (Month, Day Year)

Due to (or as a consequence of)

inela)	desease	
· · · · · · · · · · · · · · · · · · ·		

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

	24a. Was	
	1□ Yes	
26. Place of Death (C	Check only	one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 Probably 4 Unknown

th (C)	neck only one)		
• те	5 X Residence	9 6	Other
28d.	Describe how i	njury	occurred

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number

Эа.	Certifier (Check only	1 Certifying 2 Medical Ex	

ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. se(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

one)	2	and manner stated.	ation and/or investig	ation, in my opinion, death occi	urred at the time,	date and place, and due to the cau
b. Signature an	nd title of certifier	pan	m	29c. License number	9	29d. Date signed (Month, Day, Yea

30. Name and address of pirson who to letted cause of death (Item 23a) (Type, Print) fernand Princess Anne, MD 21853 30434 MH ). Stegman MD harles 31. Date filed (Month, Day, Year)

State Registrar

AUG 1 2 2005

within 24 hours a To the Funeral D

State of Maryland / Department of Health and Mental Hygien 2005 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 6 30 PM **Physician** .ugust 2005 James Oliver Webster /Medical 4b. City, Town, or Location of Death Rincess Anne 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Jomerset MANOKIN MANOR If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 10 M 20 F Director 218-14-2497 04/14/1919 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 7 is markad other than "natural", or Itams 23a or 28a-f show traumatic evant, the Medical Examerar must be notified at 1 Yes 2 □ No Director MD Somerset Chance 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23503 Deal Island Road 21821 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give WW T T 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married res, Give WWII Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural;, any injury or other traumatic event, the Medical Example. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none Waterman Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Webster Minnie J. Shores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aileen Webster/Wife 23503 Deal Island Road, Chance, MD 21821 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Beechwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 08/06/2005 Princess Anne, MD Signature of Fune al Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princes:

3a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Princess Anne, MD 21853 Approximate Interval Between Onset and Death nmediate Cause (Final Physician 4SCV) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CUPP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. nding physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 047094 NULL 5445BURY MD 21804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5- DIVISION ST NATESAN 1415 VU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 5 2005 Registrar

53	23		For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of H			giene 200	5 28112
	*14. *1	2 9	1. Decedent's Name (First, Mide	dle, Last)				2. Date of Dea		3. Time of Death
	Physicia /Medic		Huey Albert	Williams				August		05 06:42 A <sup>M</sup>
)	Examin	er	4a. Facility Name (If not instituti			4b. City, Town, or	_	ıth	4c. County of	
		,440	Prince George'  5. Social Security Number	-	Jenter Age (In yrs. last birthday)		rerly  If Under 24 Hrs	s. 8. Date of Birt		George's
	Funeral Director			1 <u>⊠</u> M 2□F	29 Yrs.	Months Days	Hours Min	. (Month, Day	13 1975	Birthplace (State or Foreign Country)  WV
.1			231-81-5698 Usual Residence of Decedent						10 10/0	
	anylan how	_	10a. State 10b. Coun		10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ➡ No
	Ba-f	ecto		ederick	Winche					21
	with ti		10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	leath	Funeral Director	405 Frog Holl	LOW Road 12. Was Decede	nt Ever in U.S. 13.	Was Decedent of Hi	ispanic Origin? (	Specify Yes or No-	USA 14. Race -	American Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heatth and Mentat Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Exerciper must be notified at	by Fun	1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Force	os? ⊋No	If Yes, specify Cuba  1 ☐ Yes 2 ☐ Mo	n, Mexican, Pue Specify:	rto Rican, etc.)	Specify:	White, etc. White
Š	2 hou	ted		ent's Education nest grade completed)	16a. Dece	edent's Usual Occupa	ation	orking	16b. Kind of Busin	ness/Industry
21	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)		life.	DO NOT use retired	()	Diking	Day	rox.
	filed wi Hygien other th	Con	8			Self Empl		/ P	Pav	er
and	nta! H	Be	17. Father's Name (First, Middle					ame (First, Middle,		
ž	should nd Mer marke	<u>م</u>	Eddie William  19a. Informant's Name/Relation		19h Mail	ing Address (Street a		a Collins		ate Zin Code)
Maryland	and 2 sho saith and n 27 is m		Madge Nicholso			rog Hollo		Winchest		22603
	es 1 and 3 of Health litem 27 r other tra		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place		Date	20c. Location - Cit	ty or Town, State
E	Pages nent of int: if it iry or o		1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		110	rch Cemete	ı	2/2005	Winchest	er. VA
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service	HW \	$\frac{1}{2}$	2. Name and Addres	ss of Facility neral Ho	me and Ch	napel, PA	21157
2 3	S. * 2		23a. Party Enter the disease,	or complications that cau ist only one cause on eas	sed the death. Do not er	112 Washir iter the mode of dyin	<b>ngton Ro</b> g, such as cardia	ad Westracory ar	ninster,	Approximate Interval Between
Tar.	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Mul	tiple as a consequence of	unde	ot w	ounc	ls	Onset and Death
(h).	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
Ć	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequence of):					
8760,	ite be iysicia ne bui	cai	<b>L</b> d.							
9	ntifica ing ph	Med	IF FEMALE:							
.O. Box	thet the death certificate be executed of by the attending physician and detached for use as the burial-transif	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal death 3 t at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	· ·
Δ.	requires thet the een signed by th hould be detache	by Pi	Part II. Other significant condi	itions contributing to deat	h but not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
ıd	v require been sig should b							1 🗆 Y	es 2 No 3	☐ Probably 4 ☐Unknown
Division of Vital Records,	e law has b	ompleted							sy prio	re autopsy findings available r to completion of cause of th?
ita	ysician: Th is certificete director, pag	BeC	25. Was case referred to medic examiner?	cal			26. Place of De	eath (Check only o		
× ×	S o D	ု	Yes 2□ No	Hospital: 1 ☐ Inp			4 Li Huising		lence 6 Other	(Specify)
n c		Certification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pend	unity and I	Day Year) Injury	A Work	y at k?	28d. Describe h	ow injury occurred	1, 2, 1
Sic	ten feat for: the	icat	3 ☐ Suicide 6 ☐ Coul		05 00:Z		Yes 2 No	28f Location (S	Street and Number	or Rural Route Number,
<u>&gt;</u>	i Siri	ertif	4 Homicide dete	mined building	etc. (Specify)	- actory, office		City or Tow	n, State) <b>[4]</b> ]	orten Ave
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certify	ying Physicien: To the be	est of my knowledge, dea	th occurred at the tim	ne, date and place		ause and mann	er as stated.
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical		at Examiner: On the basi and manner	s of examination and/or ii	nvestigation, in my or	pinion, death occ	curred at the time, o	date and place, and	due to the cause(s)
		Me	29b. Signature and tyle of certific	field	/	29c. License			29d. Date signed (#	Month, Day, Year)
	NIL		XXXX	ANX 11		0.	C.M.E.		August 07	7, 2005
	W.7		30. Name and address of person Susan Hopan, I	-		Penn Stree	et, Balt	cimore, M	aryland 2	21201
	St Sta	ite"	31. Date filed (Month, Day, Yea		istrar's Signature					
	Regist		ALIG	1 2 2005	low &	Sperte				
DH	HMH 17 Rev 1/2	001	nou			1				

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and  1- State Registrar  Certificate of Death	Mental Hygi	en 2005 28113	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  I rene Williams	2. Date of Death Month August	Day Year 3. Time of Death 0535 A M	
	Examin		4a. Fecility Name (If not institution, give street and number)  1 hecter River Hospital Center Chester to w	th U	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) 1917 MARYLAND	
	nyland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits	
	the Ma 28a-f	recto	MD QUEEN ANNE SUDLERSVILLE  10e. Street and Number 10f. Zip Code	10	Yes 2 □ No g. Citizen of What Country?	
	ath with	raiDi	107 CHARLES ST., APT. 4D 21668		USA	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, Ite Medical Examitment must be indifficed at ance.	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No Specify:  13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 □ Yes ☒ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE	
21215-0036	in 72 h n "natu Asciled	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	prking 1	6b. Kind of Business/Industry	
	filed with Hygiene other tha		College (1-4or 5+)  3	me (First, Middle, M	OWN HOME	
Maryland	should be find Mental H marked of umatic ever	To Be	Be	HENRY KEMP  TDA MAE	WALLS	aiden Sumame)
	1 and 2 sho Health and Iom 27 Is ma		19a. Informant's Name/Relationship (Type, Print)  BARBARA J. EBLING/ DAUGHTER  403 SUNRISE AVENUE, 1			
Baltimore,	ages 1 a int of Hea t: If Item f or othe		20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State  1 CHURCH HILL CEMETERY 8-1.		Oc. Location - City or Town, State	
<b>3altin</b>	permit. Pages Department of H importent: If Ite any Injury or ot once.		21. Signature of Fufferal Service Licenses 7	- 1	f FUNERAL HOME, P.A.	
	007 e d		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	, CENTREVI	LLE, MD 21617 Approximate	
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. COVCINOMATS IS		Interval Between Onset and Death	
	/Medical Examiner		Due to (or as a consequence of):			
	ted insit	Examiner	if any, leading to immediate  Due to (or as a consequence of):  Cause (Disease or injury)			
8760,	ate be executed hysicien and the burial-transit	al Exa	that initiated events c			
9	g physias the k	ledical	d			
P.O. Box	that the death certificate ed by the attending physi detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 To 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year	
	law requires that the as been signed by th 2 should be detache	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	accoluse contribute to the cause of death?	
al Records,	n: The law ricete has be	Completed		24a. Was an autopsy perform 1 Yes 2	No 1 Yes 2 No	
f Vital	Physiclen: this certific ral director,	To Be	examiner?   Hospital: \ \text{Othors}	ath <i>(Check only one)</i> Home 5 - Residen	ice 6 Other (Specify)	
on of	Jing After fune		27. Manner of Death  1 Statural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Accident investigation  M 1 Yes 2 No	28d. Describe how	v injury occurred	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)	
	e Hospit 24 hours e Funere etely fille	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the cau	use(s) and manner as stated. e and place, and due to the cause(s)	
1	To th within To th compl	Me	29b. Signature and title of centifier  29c. License number	Q 29	d. Date signed (Month, Day, Year)	
-	- // AI		70. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5 +	M ( 2// 2/)	
	Sta	- 1	31. Date filled (Month, Day, Yeer)  AUG 1 2 ZUU:	VIOW.	ri, 100 21620	
	Registr	ar	TOU IN LUUS PROME & Specific			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 28114 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 **Physician** Month Gary M. Warner August 8, 2:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2102 Chespeake Harbour Dr. East, #201 Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Director 194-30-4126 65 2-11-1940 Ohio Usual Residence of Decedent or 28e-f show 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ir than "natural", or Items 23e or the Medical Examiner must be 2102 Chesapeake Harbour Dr. East #201 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1958–63 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ 3 ☐ Widowed 4 N Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 3 years Dental Representative Dental Supplies item 27 is marked other other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H Gerald A. Warner Helen Elizabeth Charles ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1225 Cedar Tree Lane, Seffner, FL 33584 Christopher S. Warner/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ţ 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 5 Department of Importent: If any injury of once. Kalas Crematory 8-10-05 ' 4 Donation 5 Dother (Specify) Edgewater, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility George P. Kalas Funeral Home ( ) 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician COWN CANCER mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The taw requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has 1 ☐ Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a \*\*Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) To the the 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) **AUG 1** 1 2005

STANLET



UV

500

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D08118

JONNMULIS

2005

State of Maryland / Department of Health and Mental Hygien 0.051 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wirt Elizabeth Boyer 2005 August 8:43 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5586 Broadmoor Terrace, North Frederick Ijamsville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) **Funeral** Months 1 M 2 XF July 20,1960 217-86-0589 45 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State 28e-f show traumetic event, the Medical Examinations ust be notified at 1 Yes 2 No Director Frederick Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a USA 21754-9150 5586 Broadmoor Terrace, North death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Items 12. Was Decedent Ever in U.S. Armed Forces? e filed within 72 hours after de Il Hygiene. other than "natural", or Item Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important; if item 27 is marked other than any injury or other traumetic event, ITAN ODG. 4 Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ann Howard Norman Wallace Boyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert T. Wirt (Husband) 5586 Broadmoor Terrace, N., Ijamsville, MD 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State All Hallows Cemetery 8-13-2005 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service L 12 Ridgely Avenue, Annapolis, MD 21401 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final Malcanant Priysician MUS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month jo Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 PNo 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death.Funeral Director: After the Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ( D.C. 20542 2005 10 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Catlett, M.O Irving St. N.W. egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**AUG** 1 1 2005

_					_			no especialista	
Р	lease Type or Printers  State of M							egible.	
1 - For State Registrar	State of M	•	•	cate of E		ieillai Hy	Reg. No.,		
Decedent's Name (First, I	Middle, Last)					2. Date of De	-	$\frac{2005}{1000}$	3 fine of Dean
Chester C. Bent	war Sr					Month	Day	Year	5 / LISAM
			45	City Tours or	Location of Death	FULL	151	County of Dea	2 6.43.
0	itution, give street and number)		40.	City, Town, or	Location of Death		40. (	Journey of Dea	uı
	34,11	7LT Imaz			moi				
5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birt	Mo	Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay, Year)	C	thplace (State or Foreign ountry)
249-44-7302	TESTIN ZUF	71	rs.			12-25-1	933	Sout	h Ćarolina
Usual Residence of Decede		T							T
10a. State 10b. Co	ounty	10c. City, Town	or Locatio	n					10d. Inside City Limits
MD	NA			Baltin	nore				1 XYes 2 No
10e. Street and Number			10	of. Zip Code			10g. Citiz	en of What C	ountry?
508 N. Stricker	Street			212	217			USA	
11. Marital Status	12. Was Decedent Anned Forces		13. Was	Decedent of His	spanic Origin? (Sp , Mexican, Puerto	ecify Yes or N	0- 1	4. Race - Ame	
1 Never Married 2	Married 1 ☐ Yes 2 ☐					nican, etc.)		Black, Whi	le, etc.
3 Widowed 4 Dive	orced If Yes, Give Year or Dates:		101	res 2 No	Specify:			Specify: B	lack
	edent's Education	16a.	Decedent's	Usual Occupa	tion		16b. Kir	d of Business	/Industry
	nighest grade completed)	7	life. DO N	of work done d IOT use retired)	uring most of work	ing			
Elementary/Secondary (0-	·12) College (1-4or	0+)	Co	mputer O	perator			Beth!	lehem Steel
17. Father's Name (First, Mi	ddle, Last) unknown				18. Mother's Nam	e (First, Middle	, Maiden	Sumame)	
					Glades	Benbow	7		
19a. Informant's Name/Rela	ationship (Type, Print)	19b.	Mailing Ad	dress (Street a	nd Number or Run			Town, State.	Zip Code)
Arlene A. Benbo			117		Street Balt				, - = ,
20a. Method of Disposition		20b. Place of	Disposition	(Name of		Date	20c. Loc	ation - City or	Town, State
	ition 3 Removal from State			y`or other place st Vetera	á l	0.		14'11	M I J
° 4 □ Donation 5 □ Oth		Gallison			; 09-02-	-05	Owing	gs Mills	,Maryland
21. Signature of Funeral Se	rvice Licensee			me and Address	,				01017
Junes	a yours		Wy1i	e Funera	1 Home 638	N. Gilmo	or Stre	et Balt:	imore, MD 21217
23a. Part1. Enter the disease shock, or heart failure.	se, or complications that ceuse List only one cause on each I	the death. Do n	ot enter the	mode of dying	, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition	S	1 6	1.7						Onset and Death
resulting in death)	a. Due to for as	a consequence of	nf):	une	2 Car	sce!			1 year
	Due to (01 as	a consequence (	,,,.						~
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence o	of):						

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral Director** 

þ

Be Completed

ပ

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f ehow any highry or other treumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospitei or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit

Division of Vital Records, P.O. Box 68760,

ami	th re
EX	re
edical	
N/Me	IF 2:
clai	
hys	
by P	Pa
led !	_
plet	
Completed by	
Be	2
atlon; To	27
tifica	
Cert	

	Immediate Cause (Final disease or condition resulting in death)	•
sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{
slclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	2

9 Unknown

nt	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown
	4☐ Pregnant at time of death

y eath th	3 ☐Ectopic pregnancy 5 ☐ Other (specify)
-----------------	---

23d. Date of delivery			
Month	Day	Ye	

art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e.
	-

Due to (or as a consequence of)

23e. Did tobacco use contribute to the cause of death?						
1 Yes 2	] No	3 Prol	bably	4 □Unknown		
24a. Was an autopsy performed?	24b.	Were auto prior to co death? 1 \( \sum \text{Yes}		dings available on of cause of		

25. Was case referred to medical examiner?  1 Yes 2 XNo	Hospital:	1 Inpatient	2 🗆	ER/Outpatient	3 🗆 DOA
7. Manner of Death		Date of Injury (Month, Day Ye		28b. Time of Injury	28

26. Place of	Death (U	neck only one)	
Other: 4 Nursin	g Home	5 Residence	6 ☐Other (Specify
c. Injury at		Describe how ini	

27. Manner of Death	
1 XNatural	5 Pending
2 Accident	investigation
3 Suicide 4 Homicide	6 Could not be determined
4   Homicide	

29a. Certifier

28b. Time of Injury		28c. Injury
	М	1 🗆 Y

it		28d.	Describe	how	injury	occurred	
s	2 🗆 No						

☐ Suicide ☐ Homicide	determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)

et, factory, office	28f. Locati City o

6 Could not be determined	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
1 Certifying Physi 2 Medicel Examine	cian: To the best of my knowledge, death occurred at the time, date and pr: On the basis of examination and/or investigation, in my opinion, death and manner stated.	I place, and due to the cause(s) and manner as stated. h occurred at the time, date and place, and due to the cause(s)

29b.	Signature and title of certifier		
	Hansence	1.0	_
	A STUDIES	nn	1

RAC	gpiil.	0	0	0

29c. License number

AUGUST 28,2005

29d. Date signed (Month, Day, Year)

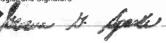
30. Name address of person who completed cause of death (Item 23a) (Type, Print)

EMD SINAL MOSPITAL OF BALTIMORE, MD 21215 KOMAL LAWRENCE 31. Date filed (Month, Day, Year)

State Registrar

Medical

AUG 2 9 2005



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dey Bellestri **Physician** 5:15 AM Eleanor 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Baltimore NUVSING Salfimore romwell If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number Qe (In yrs. lest birthday) 6. Sex **Funeral** Months Days 1□ M 217 F Director July 6, 1914 Maryland 212-10-5369 Usual Residence of Decedent be filed within 72 hours efter death with the Merylend 10c. City. Town or Location 10d. Inside City Limits 10a Stete 10b. County 1 ☐ Yes 2 X No Director 28a-f s traumatic event, the Medical Examiner must be notified Baltimore Rosedale 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code b 7401 Brightside Avenue 21237 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: þ White 3 Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) 7th College (1-4or 5+) Conductor Musical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) permit. Pages 1 end 2 should be i Depertment of Health end Mental I Important: If Item 27 ia marked of Walter Malinowski Natalia (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Baltimore, MD 21162
Date 20c. Location - City or Town, State Mary Theiss/daughter 11736 Hamilton Place other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or 8/29/05 Baltimore, Maryland Holly Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licensee 1211 Chesaco Avenue Rosedale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or as a conseque Physician/Medical Examiner the buriel-trensit Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4, □ Unknown 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed 1 735 2 MINU 1 ☐ Yes 2 ☐ No entenor 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospitel: Medical Certification: To 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury et Work? 27. Menny of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier no. MO

\* Sind

₩ Star

State Registrar 31. Dete filed (Month, Day, Year) AUG 2

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

132. Registrer's Signature

		•	For State Registrar	State of Maryla		irtment of F			giene Reg. No. 2005	28118
	Physicia	an	1. Decedent's Name (First, Middle, Last) Frances	Α.	В	arnes		2. Date of Dea Month		3. Time of Death 7:50 A <sup>M</sup>
}	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)			r Location of Death	nugust	4c. County of Death	
			Perring Parkway Nur			Parky			Baltimor	
	Funeral Director		210 01 3077	2 1 F 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Decembe		nplace (State or Foreign untry) Maryland
	fand		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary Pa-f sh	tor	MD N/A		Baltimo	ore				1 XYes 2 □ No
	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Cîtîzen of What Co	untry?
	s 23a		4007 The Alameda	W D d C cial	10 40 1		8-1357	anifu Van ar Na	U.S.A.	ican Indian
36	be filed within 72 hours after death with the Maryland ital Hygiene. It has say or 28e-f show to other than "natural; or fems 23e or 28e-f show event, the Marical Examitter: sast by notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in I Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
21215-0036	2 hou	ted	15. Decedent's Educat	ion	16a. Deced	dent's Usual Occup	eation during most of work	ing	16b. Kind of Business/I	ndustry
215	ithin 7 ie. ien "n	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	d)	nig		
	filed with Hygiene other tha ent, Ine A		17. Father's Name (First, Middle, Last)		C C	lerk/Typi		a (First Middle	Banking Maiden Sumame)	
anc	d ba fi	э Ве	Charles W. Simmor						nderson	
Maryland	2 should ba and Mental Is markad o	O_	19a. Informant's Name/Relationship (Type		19b. Mailir	g Address (Street			r, City or Town, State, Z	ip Code)
	d 2 T is		Mrs.Lillian Strohmi	nger- Siste	r 4007	The Alam	eda Balti	more, M	aryland 212	18-1357
ore	es 1 and the litter of the lit		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other pla	сө)	Date	20c. Location - City or	Town, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		* 4  Donation 5 □ Other (Specify)	Mc		/ Redeeme			Baltimore,	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	Heather Ca	11n   22	name and Addre	Buck Tr	ltimore,	Maryland 2 5 Harford F	21214
			23a. Part1. Enter the disease, or complica	tions that caused the dea						Approximate Interval Between
	Pnysician	6 10	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	Mu	rees	do in	(ari	E.	Onset and Death
	/Medical		disease or condition resulting in death)	Due to ( as a conse	equence of):	0		500	E.n	Let con
į.	Examiner		Sequentially list conditions, b.	100		ic H	cont	de:	ress'	yeur
	pe:	niner	Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury	Due to (or as a conse	equence of):				21	Ŋ
	be executed ician and burial-transit	Exami	that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):					
8760,	cate be ex ohysician the buria	dical E	d							
9	the death certificate be executed y the attending physician and iched for use as the burial-transif	a u	IF FEMALE:							
Вох	eath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of preging 1 Live birth 2 Fe	tal death 3	Ectopic pregnanc	y		23d. Date of deli Month	very Day Year
<u>o</u>	that the de ed by the a detached f	Physiclan/M	1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5	] Other (s <i>pecify)</i> _				
0	ires that the signed by does does	by Ph	Part II. Other significant conditions contri	•	- 7	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
rds	The law requires that ste has baen signed b page 2 should be dete		(erebrion	sulm	X	Jero	e	101	es 2 0 10 3 □ Pro	obably 4 Unknown
oce	e law re has bae je 2 sho	plet						24a. Was	sv prior to d	topsy findings available completion of cause of
E E		Completed						perfo Yes	rmed? death? 2☑No 1☐Yes	2 No
Vital Records,	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	spital:		Ott	26. Place of Deal			
of	Phys r this sral di	To :	1 Yes 2 10	28a. Date of Injury	ER/Outpatier 28b. Time o	28c. Inju	ry at		dence 6 □Other (Spec now injury occurred	ify)
ion	Attending F death. ctor: After y the funer	atlor	1	(Month, Day Year)	Injury	M 1	rk?  Yes 2 □No			
Division	or A	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (S City or Tox	Street a <i>nd Number or Ru</i> vn, State)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	edical (		ian. To the best of my ki r: On the basis of examinand manner stated.						
	To th withir To th comp	ĕ	29b. Signature and title of certifier			29c. Licens	se number	1	29d. Date signed (Month	, Day, Year)
}	of		Mount	-1-0 F	A.D	100	008368	3	Hug 26	2005
	101		30. Name and address of person who com  (C) PLU (P)  31. Date filed (Month, Day, Year)	pleted cause of death (Ite	em 23a) (Type, 7)	Print) 84 0 3	3 HA	CARO	20 Pot	7
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature _a	BAC	A. MA	11090	1000	14
	Registi			8 > 1	Con	W BAC				
Di	HMH 17 Rev 1/2	001	AUG 2 9 2005	REPRIES BY						

ORIGINAL

			For Stete Registrar	State of Mary		artment of H rtificate of L			ene		
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  CAROLINE			Bucc	./	2. Date of Death Month	Day 25 2005	3.50 A M	
	Examir Funeral Director		4a. Facility Name (If not institution, give strains) 5. Social Security Number 6. Sex 10. N	inc Hospi	yrs. last birthday) 76 Yrs.	4b. City, Town, or If Under 1 Year Months Days	Location of Dea MORE If Under 24 Hrs Hours Min	8. Date of Birth	rear) Co	h hplace (State or Foreign untry) yland	
	D		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ocation			.920 Hat	10d. Inside City Limits	
	ith the Ma or 28e-f	Director	Maryland Baltimor  10e. Street and Number		Catons	ville 10f. Zip Code		10	g. Citizen of What Co	1 ☐ Yes 2 🖺 No untry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Pygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, If a Modical Examination to motified all once.	by Funeral I	2204 Pleasant Dri  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Ve. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		21 Was Decedent of Hi If Yes, specify Cuba 1□ Yes 2₺ No	228 spanic Origin? (Sn, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	U.S.A.  14. Race - Ame Black, White Specify:		
21215-0036	d within 72 hou giene. ør than "natura ør Wedical E	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)  Bookkeeper							16b. Kind of Business/Ir		
Maryland	uld be file Vental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) Harvey Krause					me (First, Middle, M ara Ihle	aiden Sumame)		
	and 2 sho alth and A 127 Is ma er trauma	•	19a. Informant's Name/Relationship (Type Alfred Bucci (Hus	. <i>Print)</i> sband)		ng Address (Street a			City or Town, State, 2 1e, Mary 1a		
altimore,	Pages 1 ament of He ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Ob. Place of Dispo		g)	Date 2	Oc. Location - City or	Town, State	
Balt	permit. Departimport any inj		21. Signature of Funeral Service Licensee	Telmes	Wi Wi	2. Name and Addres tzke Fune 30 Edmond	ral Home	e of Cator	nsville, I	nc.	
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	tions that caused the cause on each line.  Coronari  Due to (or as a				ic or respiratory arres		Approximate Interval Between Onset and Death  Two Months	
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co							
.O. Box 6	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pr 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year	
rds, P	quires that in signed b	þ	Part II. Other significant conditions contri Renal failure	buting to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
Vital Records,		Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of	
	ysiclan: is certific director,	To Be (	25. Was case referred to medical examiner?  1 Yes 2 No Hos	pital:	2 ER/Outpatier	nt 3 DOA Othe	r	ath (Check only one)	ce 6 Other (Spec	eify)	
sion of	ding h. After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Work	at	28d. Describe how			
Division	or A	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)			City or Town,			
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Exemine	ien: To the best of my r: On the basis of exa and manner stated.	/ knowledge, deati mination and/or in	n occurred at the tim vestigation, in my op	e, date and place sinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)	
)	To t To the	W	29b. Signature and title of certifier.	alt		29c. License		0 A	d. Date signed (Month	, Day, Year) 5, 2005	
	10		30. Name and address of person who come Kelly Brungard	oleted cause of death	(Item 23a) (Type,	Print)	Baltin	Oce Mas	ygust 25	0/287	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 9 200	32. Raistrar's S	Signature	barle	,	) /			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer **Physician** Jeannice Bulson 8:20 a. August 23, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Ellicott City Howard 2800 Deerfield Dr. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 X F Yrs. Director 82 443-16-9656 February 11, 1923 Texas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A. 2800 Deerfield Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Maggie Northcutt Buford Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If itam 27 Is
any injury or other trau
once. 2800 Deerfield Dr. Ellicott City, Maryland 21043 Mr. Edwin L. Bulson Husband 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) 08/26/2005 Elkridge, Maryland Meadowridge Memorial Park, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Slack Funeral Home, P.A. 23a. Part1. Ener the displace or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2. No 9 ☐ Unknown the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed/ certificate 2□ No 1 Yes 2**X**(No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۲ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3☐ DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dire 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 50870 lane Clariselle MD who completed cause of death (Item 23a) (Type, Print) gna Suzan

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		•	For State Registrar		State	of Ma	ryland / Dep <i>Ce</i>	artment of H			jiene No. 2	005	28121
	Dhusish		Decedent's Nam		e, Last)			^		2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic	al -	Florence						mdon	August	21	2005	3:15 AM
	Examin	er .	4a. Facility Name (	If not institution	n, give street and n	umber)	coilal	4b. City, Town, or	Location of Dear	in 15	4 <b>c</b> . Col	unty of Death	
	Francis		5. Social Security N	Number S	6. Sex	7. Age	(In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	1	9. Birthp	lace (State or Foreign
	Funeral Director		246-38-67		1 ☐ M 2 🖫 ۴	89	Yrs.	Months Days	Hours Min	(Month, Da)		North	Carolina
	p >		Usual Residence of				10c. City, Town or L	ocation					0d. Inside City Limits
	Aaryla shov	ū	Md	N/A			Baltimore					1	149 Yes 2 No
	the N	Director	10e. Street and Nu					10f. Zip Code			10g. Citizen	of What Cour	ntry?
	h with		1401 E.	01iver	Street			2121	3		II.S.		
	deat	ner	11. Marital Status		12. Was De		ver in U.S. 13.	Was Decedent of H	ispanic Origin? (9	Specify Yes or No- to Rican, etc.)	14.	Race - Americ Black, White,	
36	s after , or Ite	by Funeral	1 ☐ Never Man		ried 1 Tyes	ive 2 → No	5	1 ☐ Yes 2 ☐ No	Specify:			ecify: Bla	
21215-0036	within 72 hours after death with the Maryland ene. than "natural" or Items 23a or 28a-f show than "holical Examinar mast be mailfied at	ed b	2 Standowed		Year or	Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind o	of Business/Inc	
215	nin 72 nin "na	Completed	(Spe	cify only highe	st grade completed	d) (1-4or 54	life.	kind of work done of DO NOT use retired	during most of wo f)	orking			ŕ
	e filed withi al Hygiene. other than vent, the M	Som	1	2			Home	e Maker			House		
Maryland	be file	Be	17. Father's Name		Last)					me (First, Middle,	Maiden Sur	name)	
Z	should be nd Mental marked o	으	Henry F		thin (Tyne Print)		19h Mail	ng Address (Street		Watkins	r City or To	wn State Zin	(Code)
$\mathbf{z}$	nd 2 sho lth and 27 Is mu		Eli Bran					SE 19 Lane		Coral, F			
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ital Marylan Examinat must be notified at ance.	li	20a. Method of Dis				20b. Place of Disp			Date		on - City or To	
altimore,			1 Surial 2 1 4 □ Donation		3 □Removal from Specify)	m State		Cemetery		23/2005	Balti	more,	Maryland
Balti	permit. Pages Department of h Important: If ite any injury or of		21. Signature of F	uneral Service	Licensee		70	2. Name and Addres	ss of Facility Wi	se Funera	al Ser	vices,	P.A. land 21229
			23a. Part1. Enter	the disease, o	r complications that only one cause on	t caused	the death. Do not en					. Par v	Approximate Interval Between
	Priysician i	0 1	Immediate Cause	(Final			Brain	Injury				(	Onset and Death
	/Medical Examiner		resulting in death)	)	Due to	o (or as a	consequence of):	3)					
		_	Sequentially list c	onditions,	0.		ac Amest	MAHA	oute sho	KS			6 aus
		Examine	li any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										J
Ć,	execu in and ial-tra	Exal	resulting in death)	ts Last	C. Due to	o (or as a	consequence of):						
8760,	cate be executed physician and the burial-transit	dlcal			d			<u></u>					
9		0	IF FEMALE:				,						- 57 - 57 (
Вох	The law requires that the death certificate has been signed by the attending plagge 2 should be detached for use as it	Physician/M	23b. Was deceded in the past 12	2 months?		birth 2	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d.	Date of delive Month	ery Day Year
o.	that the dened by the a	ysic	1 ☐ Yes 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No n	9 Unl		inte of death 3	Other (specify)					
<u>a</u>	res that igned b be deta	by Pl	Part II. Dther sign	ificant conditi	ons contributing to	death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	ne cause of death?
rds	w require been sig should b	ed b		Moot	moidis	M				1 □ Y	es 2ĂN	o 3∏Prob	pably 4 Unknown
Records,	law requas been 2 should	plet		<u> </u>						24a. Was autop			psy findings available impletion of cause of
- H		Completed								perfor	med? 2 X No	death?	2 No
Vital	Physician: this certific ral director,	Be	25. Was case refe examiner?					oth Oth	or	eath (Check only o			
of	Phy r this ral d	-: To	1 Yes 22 27. Manner of Dea	No ath	Hospital: 1)	te of Injury	28b. Time (	nt 3 DOA	4   Nursing	Home 5 Resid			y)
On	Attending Ph ir death. ector: After th by the funeral	atlor	1 Natural 2 Accident	5 🗌 Pendi		onth, Day	Year) Injury		k? Yes 2∐No				
Division	Attendil er death. ector: A by the fu	tiflea	3 Suicide	6 ☐ Could deterr	nined 208. Fla	ce of Inju	ry - At home, farm, s . (Specify)	reet, factory, office		28f. Location (S City or Tow		umber or Rura	al Route Number,
	ital or rs afte ral Dir led in	Cer			1					li .			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier (Check only one)				f my knowledge, dea examination and/or i led.						
	To the To the Comp	ž	29b. Signature an	d title of certific	er .			29c. Licens	e number		29d. Date si	gned (Month,	Day, Year)
	6		PWW	NK	~ M.D.			Ves	#T500	29	AUSU	st 21	2003
í	7			dress of person	who completed ca	use of de	examination and/or ited.  ath (Item 23a) (Type 200 Y \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Print)	a41	· Mn	フリン	47 <del>-</del>	
	Sta	ate	Orm 31. Date filed (Mo	onth, Day, Year	0 0 200 32.	. Registra	r's Signature	111031,0	**( 14/104		_ , _	J (	
	Regist			AUG	2 9 2005	) De	elva St.	Sparke					

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of			glene Reg. N <b>2</b> 0 0 5	28122		
	Physici	an	Decedent's Name (First, Middle Yvette	e, <i>Last)</i> Chagi	non			2. Date of Dea Month August	ath Pay 2005	3. Time of Death		
	/Medic Examin	al	4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death		4c. County of Dea	5:45 P.M		
	LXaIIIII	CI	9371 King Grant			Laurel			Howard			
	Funeral Director		5. Social Security Number 027-24-6410	6. Sex 7. Ag	ge (In yrs. last birthda 72 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 9/13/193	y, Year) 9. Bir 2 Ma	rthplace (State or Foreign ountry) i ne		
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
	e Mary ta-fsh timed	ctor	MD Howa	rd	Laurel					1 ☐ Yes 2 🖾 No		
	vith the	Director	10e. Street and Number			10f. Zip Code 20723			10g. Citizen of What C	ountry?		
	ns 23e	Funerai	9371 King Grant 11. Marital Status	12. Was Decedent	Ever in U.S. 13		lispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Am	erican Indian.		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other then "naturel; or Items 23a or 28a-f show other treumatic event, the Modical Examination and the notified at	þ	1 ☐ Never Married 2 💢 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puèrto Specify:	Rican, etc.)	Specific			
2	"natur	etec	15. Deceden (Specify only highe	t's Education st grade completed)	(Gi	edent's Usual Occup re kind of work done	during most of work	ing	16b. Kind of Business	s/Industry		
121	withir iene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired mema ker	a)		Own Home			
Maryland 21215-0036	should be filed and Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Albert Mandeville	*			18. Mother's Nam Regina E		Maiden Sumame)			
Mary	ind 2 shou alth and M 27 Is mar ir treumat		9a. Informant's Name/Relationship (Type, Print)  Normand Chagnon / Husband  9371 King Grant Road, Laurel, Maryland  200. Place of Disposition  200. Place of Disposition (Name of Date 200. Location - City or Town, State, Z									
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre once.		20a. Method of Disposition  1X Burial 2 Cremation  4 Donation 5 Other (5	3 □Removal from State	cemetery, cr	position (Name of ematory or other place al Cemetery	ce)	Date 5/2005	20c. Location - City or Laurel, Mar			
Balt	permit. Departn Imports any inju		21. Sign was neral strvice	Licensee		22. Name and Addre 7601 Sandy			al Home, Inc. , Maryland 20			
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Advanced Alzheimers Disease Years									
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
		Jer	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oue to (or as	a consequence of):					922		
	ecuted and -transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):							
68760,	tificate be executed g physician and as the burial-transit	edicai E		d.	a consequence of).							
	certific ding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of de	livery		
P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/M	in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown		☐ Ectopic pregnancy ☐ Other (specify)	'		Month	Day Year		
S,	es thai igned b	by P	Part II. Other significant condition		out not resulting in the	underlying cause giv	en in Part I,		Be. Did tobacco use contribute to the cause of death?			
ord	requir	eted	Hyperte							robably 4XXUnknown		
Vital Records,	The far ate has page 2	Completed	Hyperli	pidemia				24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of		
<u> </u>	sician certifi iractor	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:		ont 30 DOA Oth	26. Place of Deat					
סר	ig Phy ter this neral d	$\vdash$ 1	27. Manner of Death	1 ☐ Inpatie	ry 28b, Time	SIL 3 DOX	y at	.,,	ence 6 Other (Spe ow injury occurred	icity)		
SIO	Attending Physician: If death. ector: After this certific by the funeral director.	catio	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	gation	y 7 dai/ injury		Yes 2 □ No					
Division of	i i i	Certification:	4 Homicide determ	ined 28e. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Si City or Town	treet and Number or Ri n, State)	ural Route Number,		
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edicai C	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the best Examiner: On the basis o and manner st	f examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occurr	and due to the cred at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifie	1-40		29c. Licens	e number	2	9d. Date signed (Mont	th, Day, Year)		
	. 1		1	VI 8/1	2		422		August 23, 2	005		
	H		30. Name and address of person Robert Maggin, Ma		leath (Item 23a) (Type imore Avenue		ryland 2070	7				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	W.						
	negisti	×1.	AUG 2 9 201	J. J. B. B. J. F. S.	200 July -							

			1 - For State Registrar	State of Maryla		artment of F			ene No 2005	28123
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	Janet Marie Dennle					August 2		3:10 P M
	Examir	ner	4a. Facility Name (If not institution, give s			, ,	or Location of Death		4c. County of Death	
	Funeral		7900 Benesch Circle 5. Social Security Number 6. Sex		. last birthday)	Glen Bu:	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	Anne Arund 9. Birthr	el place (State or Foreign ntry)
	Director		214 50 7742	M 2∏F	62 Yrs.	Months Days	Hours Min.	June 19,	1943 Mary	land
	yland Now		10a. State 10b. County	10c. C	ity, Town or Lo	cation			1	0d. Inside City Limits
	a-f st	ctor	Maryland Anne Arus	ndel GJ	len Bur	nie				1 ☐ Yes 21 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cour	ntry?
	s 23a		7900 Benesch Circle		10 10	21060			ited State	
	items items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent Ever in the Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No</li> </ol>		Mas Decedent of F f Yes, specify Cub	fispanic Origin? (Spa an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
Maryland 21215-0036	s within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28a-1 show the Medical Examérat marthust be multiled at	by	3 X Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify: wh	ite
5-0	72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occup	during most of work	ing 16	b. Kind of Business/In-	dustry
121	within ene. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire maker	d)		. H	
d 2	Hy en th		17. Father's Name (First, Middle, Last)		Home	maker	18. Mother's Name	(First, Middle, Ma	Own Home	
an	og ag ag	To Be	Thomas William Oua	isnev				ırvJane Wa		
ary		}	19a. Informant's Name/Relationship (Typ	-=/	19b. Mailir	ng Address (Street			ity or Town, State, Zip	Code)
Σ,	1 and 2 Health a tem 27 le		Brenda Mangold / I		The second second second second	West Park		timore, N		
ore			20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re	1	Place of Dispo cemetery, cren	sition (Name of natory or other plac	cal		c. Location - City or To	wn, State
Ë	Pages tment of I tent: if its jury or o		'4 ☐Donation 5 ☐ Other (Specify)	G1e		n Mem. Pa		005', GI	len Burnie,	Maryland
Baltimore,	permit. Page Department of Importent: if any injury or once.		21. Signatur Funeral Service License	9		Name and Addre	Ruddick Fu	neral Hon	ne, P.A.	
			23a. Part1. Enter the disease, or compline	ons that caused the dea		421 Crair	1 Hwy. S.F	. Glen I	Burnie, MD	21061 Approximate
	Constitution .		shock, or heart failure. List only of Immediate Cause (Final	a cause on each line.	1.					Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a conse		1 0	Chroni	C OWS V	2 Om	
	Examiner		Signification of the Secretary Secre			, r	al volunce	14 01	stuse	
V	ν <del>!</del>	Iner	5 quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):			76		
1	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	Tuonoo of):					<del>-</del>
8760,	tate be executed the side of the purial-transit	cal E		Due to (or as a consec	quence or).					
687	ficate physis the	9	d.	201024						
Вох	leath certific attending p I for use as 1	n/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregn					23d. Date of delive	iry
-	e death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1☐Live birth 2☐Feta 4☐Pregnant at time of of 9☐Unknown		Ectopic pregnancy Other (specify) _	/		Month	Day Year
P.0	that the de led by the a detached t	Phy	9 Unknown							
Records,	o De	d by	Part II. Other significant conditions cont		suiting in the ur	nderiying cause giv	en in Part I.	1 X Yes	co use contribute to th	ably 4 □Unknown
Sor	w requir been si should	Completed	7,52.12					24a. Was an		
Re	0 5 0	dmo						autopsy performed	prior to cor death?	csy findings available mpletion of cause of
Vital		e Cc	25. Was case referred to medical				26. Place of Death	1 Yes 2	Wo 1□Yes	No No
<u> </u>	S S	To B	examiner?	ospital:	] ER/Outpatien	t 3 DOA Oth	05		e 6 ☐Other (Specify	1)
n of	ding Phy h. After thi funeral		27. Manner of Death 1 28 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe how i		,
Sio	Attending r death. ector: After by the funer	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stre	eet, factory, office	;	28f. Location (Stree City or Town, S	t and Number or Rura. tate)	l Route Number,
_	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	(Check only 2 Medical Examin	cian: To the best of my knor: On the basis of examination	owledge, death	occurred at the tir	πe, date and place, a	and due to the caus	e(s) and manner as st	ated.
	thin 2 the the	Med	29b. Signature and Ne of certifier	and manner stated.		29c. Licens			Date signed (Month, I	
}	Z 2 Z 8		\$ A	ww -	· MD	7	rical		-	
	10		30. Name and address of person who cor	npleted cause of death (Itel	m 23a) (Tvne	Print)	21276	HU	gust 25	, 2003
	9		K. Ambalavano	1845	Ocalan	good Ro	ad 103,	GlonB	urniè n	1D,2106/
	Sta Registr		AUG 2 9 2005	Je. Hogistra's sign	perte					

			1 _ For	State of Marylar	nd / Departme		and Menta	Hygiene	•2กกร	28124
45	Physic		1. Decedent's Name (First, Middle, Las	ise Dickers		ate of Death	2. Date	2	y Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give		al 4b. C	ity Town/or/Location	of Death	7	County of Deat N/A	
**	Funeral Director		011 30 1110	2 X 7. Age (In yrs. 6	9 Yrs. If Un	der 1 Year If Under ns Days Hours	Min. 8. Date	of Birth th, Day, Year, MARY 4,	1936 St	hplace (State or Foreign
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Margund N	A 10c. C	ity, Town or Location	ire.				10d. Inside City Limits 1 ▼Yes 2 □ No
	h with the	Funeral Director	10e. Street and Number 1040 East 33"	d Street Ap	7.0(1.1.	Zip Code 2/2/8		10g,Ci	tizen of What Co	,
036	within 72 hours after death with the Maryland ane. then "natural", or Items 23e or 28e-f show the Medical Evantiner count by confilled at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Ori pecify Cuban, Mexicar 2 No Specify:			14. Race - Ame Black, Whit Specify:	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Mental Hygtene. If item 27 Is marked other then "natural", or Items 23s or 28s -f ehov or other traumatic event, the Medical Examinational Remodified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO	work done during mos Tuse retired)	t of working		onush	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental aumatic event, the Mental aumatic event.	To Be	17. Father's Name (First, Middle, Last) Kedah Sutt	on		I	r's Name (First, )	oung	·	
	s 1 and 2 sh of Health and item 27 Is m other traum			n-Husband	19b. Mailing Addr 1040 E	ess (Street and Number 3 3April 20	f. Bal			
Baltimore,	Pa anti-		20a. Method of Disposition  1 X Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	the state of the s	Place of Disposition (I cemetery, crematory of MCMC/I		Aug Date 31	Bo	ocation - City or	e, MD.
Bai	permit. Departr Importe eny inji		21. Signature of Funeral Service Licens	ttund	P.O. 6	and Aldress by Facily	Baltome	re, Ma	service, ryland	21259
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	· Cerebral	Vascu	lar Acc				Approximate Interval Between Onset and Death  2 WRCK
*	Examiner	er		b. Due to (or as a consect by perfect by Due to for as a consect by Due to for a consect by Due to for as a consect by Due to for a consect b	quence of):					25 years
760, 6	te be executed ysicien and ne burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	<u> </u>					25 years
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3 □Ectopio				23d. Date of deli Month	very Day Year
Δ.	signed by	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e.		/	the cause of death?
I Records,		Completed					24a.	Was an autopsy performed?	24b. Were au	lopsy findings available ompletion of cause of
Vital	sicien: certific rector,	o Be (	25. Was case referred to medical examiner?	Hospital:		Other	of Death   Check	only one)		
of	Jing After fune	H	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?		Residence cribe how injur		ıfy)
Division	iel or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Loca City	tion (Street an or Town, State	d Number or Ru )	ral Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director; cumpletely filled in by the	edicai	one)	rsician: To the best of my known. On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and on, in my opinion, deat	d place, and due t th occurred at the	o the cause(s) time, date and	and manner as I place, and due	stated. to the cause(s)
	To the vithin 2 To the cumplet	Σ	29b. Signature and title of certifier			9c. License number		29d. Dat	e signed (Month	
,	, Ç		30. Name and address of person who co	orneleted cause of death (Iter		AT24389		Au		2005
	N		THY NGUYE	N, M.D. L	luion 14	tmorial	Hospita	L. in	D	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 2005	orheleied cause of death (iter  M. D. (  36. Registrar's Signs	Lature Sparke		*	,		

	1	For State Registrar	State of Marylar	nd / Depa	artment of Heali	th and Me	ental Hyg	giene Reg. No.	2005
Physician /Medical Examiner		I. Decedent's Name (First, Middle, Lastia. Facility Name (If not institution, give	Soh	n T	Flans 4b. City, Town, or Loca Balta	tion of Death	Date of Dea Month Augus t	Day 34 4c. Coun N	Yeer 3. Time of each 2005 10:00 At ty of Death A
Funeral Director		5. Social Security Number 6. S 1 229 – 01 – 2951  Jsual Residence of Decedent	XM 2□F 84	. last birthday) Yrs.	Months Days Ho	ndeř 24 Hrs. urs Min.	Date of Birth (Month, Day 01/06	(, /ear) 1921	9. Birthplace (State or Fore Country) VIRGINIA
within 72 hours after death with the Maryland sne. than "naturel", or items 23a or 28e-f show item "raturel" and item in and the incilling at many least the incilling at impleted by Funeral Director		MD 10b. County N/A		BALTII	MORE CITY				10d. Inside City Limi
N with the 13a or 2a at Lenna at Lenna at Dire		10e. Street and Number 5009 FRANKFOR	D AVENUE		10f. Zip Code 21206			10g. Citizen o USA	f What Country?
urs after death with the Ma et, or items 23a or 28e-f s exertiver reset to notified by Funeral Director		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ₹ \$ Vidowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 12 Yes 2 □ No U If Yes, Give Year or Dates: AR	5	Was Decedent of Hispani f Yes, specify Cuban, Me i ☐ Yes 2 No Spe	c Origin? (Spec xican, Puerto R ecify:	ify Yes or No- can, etc.)		ace - American Indian, ack, White, etc. ify: BLACK
	-	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12TH		(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working		SPARR	Business/Industry OWSPOINT EHEM STEEL
Mental Hyginarked other ettic event, I		17. Father's Name (First, Middle, Last) SMITH EVANS				Aother's Name (	CAL	HOUN	
f Health and Item 27 is m	-	19a. Informant's Name/Relationship ( DARLENE E. ROS 20a. Method of Disposition	COE/DAUGHTE 20b.	R 4925	ng Address (Street and No.  GOODNOW sition (Name of natory or other place)		т. г,	BALT	n, <i>State, Zip Code)</i> 2120 I MORE <u>MD</u> 1 - City or Town, State
Department of Importent: If Importent: Importen	-	4 □ Donation 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of the control of the cont	)	D <sub>R</sub> VETE ARRIS	ERANS CEM . N FOREST . Name and Address of F				S MILLS, MD L HOME 21207
cale be executed physician and physician and the burial-transit the burial-transit dical Examiner		23a Annt Inter the ase, or commoder heart ure. List only Imm die Cause (Final dise per or condition resulting in death)  Sequentially list conditions, if any, leading to immediate educe. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		quence of):	E DEME				Onset and Death
The law requires that the death certifica tate has been signed by the attending phoage 2 should be detached for use as the completed by Physician/Medicompleted by Physician Physicin Physician Physician Physician Physician Physician Physician Phy		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)				ate of delivery fonth Day Year
on signed build be deta		Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause given in F	Part I.		obacco use co ′es 2 □ No	ntribute to the cause of death2
	1						24a. Was a autop perfor	SV	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
entific ector Be		25. Was case referred to medical examiner?	Hospital:	7-7-0	Other	Place of Death (			
fing After funer		1 ☐ Yes 2 ☑ No  27. Mann of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28		lence 6 🗀 O	
itel or irs afte rel Dir led in I		3 Suicide 6 Could not be determined	building, etc. (Spec	eify)			City or Tow	m, State)	nber or Rural Route Number,
the Hospitel thin 24 hours a the Funerel impletely filled		29a. Certifier (Check only one)  2□ Medical Examone)  29b. Sign tu/e and title of certifier	ysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, deat eation and/or in	o occurred at the time, da vestigation, in my opinion 29c. License num	, death occurred	at the time, o	date and place	nanner as stated.  a, and due to the cause(s)  ed (Month, Day, Year)
5 ¥ 5 0 0 N		30, Narre and address of person who	completed cause of death //i-	am 23a\/T.ma	D542	127		8/2	4 05
State		30. Name and address of person who all the state of the s	completed cause of death (ite	Man	het Plat	e D	und	sele	MD 21222

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelibite tilk. Assure All Capital And Explana State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 23 Dey **Physician** JOHN ENSOR - H. AUG 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner BALTIMONE Rosedale MANOR CARE NUISING Home ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months 84 Dec 13,1920 MD 213-12-4901 Yrs. Director Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantel Hygiene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f above any Injury or other trauments event 10a. Stete 10c. City, Town or Location 10d. Inside City Limits HARFORD 1 ☐ Yes 2 ☑ No Director MD Churchville 10e. Street end Number 10g. Citizen of What Country? 21028 U.S.A. 525 ASBUTY RD Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0020 Specify: White 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self. 12+4 MAINTANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EPPERS George ENSOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Asbury RD. Churchville, MD 21028. ENSOR John 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 8/29/05 BAYVIEW Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Have Then M. 1/12 - STella Funesal Home 21. Signature of Funeral Service Licenses HARTLEY Miller Bolto. Mo 21234 7527 harford RO. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL ANTARCTION /Medical Examine Due to (or as e consequence of): ARRYTHMIA Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completaly fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier D55306 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Sufe 200 BACTO MD 21237 9106 PHLADELIHA DSUNIS . H. EDIG RO 32. Registrer's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2005 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 200 nes /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner **GAITHERSBURG** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. 8. Date of Birth (Month, Day, Year) SEPT 20, 1941 Birthplace (State or Foreign Country)
 INDIA **Funeral** Days Hours 1 ☐ M 2 🗓 F 63 218-08-4338 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h Counts Item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumetic event, the Medical Examinal must be notified at 1 X Yes 2 No **GAITHERSBURG** Director MONTGOMERY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? CEVILLE WAY **GAITHERSBURG** USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours efter 1 ☐ Never Married 2 X Married Specify: INDIAN SIKH Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes, Give þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if Item 27 is marked other than any injury or other traumath Elementary/Secondary (0-12) College (1-4or 5+) **TEACHER EDUCATION** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BALWANT SINGH RAM KAUR ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 CEVILLE WAY, GAITHERSBURG, MARYLAND 20878 BHUPINDER GABRI / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee CHESAPEAKE CREMATORY 8/22/2005 BELTSVILLE, MARYLAND 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 9 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 NM 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dirata The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year ó Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No deteched 9□ Uлклоwn 9 ☐ Unknown ģ been signed be should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? certificate 2[] No 2 🔀 No 1 Yes To the Hospitel or Attending Physicien: Be director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Hospital: ٩ 1 ☐ Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident in by the hours after deat 6 ☐ Could not be 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel D filled 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Douma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAIMA KHAWAJA, MD 11119 ROCKVILLE PIKE, #100, ROCKVILLE, MARYLAND 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 2 9 2005

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	Marylan		artment o				Reg. No. 2	005	281	21
	Physici /Medio		1. Decedent's Name (First, Middle Mary Delia G							2. Date of De Month August	26, 200	Year 5	3. Time of Death	
-	Examin		4a. Facility Name (If not institution Ridgeway Man				_	n, or Location	of Death		4c. County o	of Death	*A	
	Funeral Director		5. Social Security Number 219–10–7004	6. Sex 7 1 ☐ M 2 🖾 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da	ar If Under	Min.	8. Date of Bi (Month, D March	rth ay, Year)	9. Birthpl: Count	ace (State or Fore	eign .
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Howar	đ		y, Town or Lo	cation	,				10	od. Inside City Lim	
	with the	I Directo	10e. Street and Number 3332 N. Chatham			LIIICO	10f. Zip Cod				10g. Citizen of W	hat Count	ry?	
36	2 should be filed within 72 hours after death with the Maryland and Menth Hygiene.  In marked other than "natural", or Itema 23e or 28e-f show is marked other than "natural", or Itema 23e or 28e-f show aumatic event, the Madical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceder Armed Force	nt Ever in U. s? S≵No		Was Decedent of Yes, specify 0	of Hispanic Or Cuban, Mexica		cify Yes or N Rican, etc.)	0- 14. Race	- America k, White, e		
21215-0036	within 72 hou ane. Ihan "natura an Madical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education		(Give	dent's Usual Oc kind of work do DO NOT use re	ne during mos tired)		g	16b. Kind of Bus		,	
70	S la b	To Be Co	17. Father's Name (First, Middle, Earle Dingle			Servi	ce Repr	18. Moth	er's Name	(First, Middle ne Bla	, Maiden Sumame	<del></del>	e Company	y
	ウモア デ	Ì	19a. Informant's Name/Relationsh Vincent Garvey		ısband	3332	North	Chatha	m Roa		D, Ellic	ott (	City,MD 2	210
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other ance.		20a. Method of Disposition  1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)  21. Signature of Fundial Service	pecify)	(B	w Cath			8/30/	2005	20c. Location - (	e, Ma	ryland	
Ba	Department of the population o		23a. Part1. Enter the disease, or	complications that caus	ed the deati		736 Edm	ondson	Aven	ue;Cat	uneral Hoonsville	, MD	21228 Approximate	
	Physician /Medical		shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a	as a consequ	JCV uence of):	D						Interval Between Onset and Death	
	sicien and Sicien and Durial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence as a c	Hu	16~	When	~				74. 74.	
ς 68760,	ate the	cal	IF FEMALE:	d										
.O. Box	at the death certific by the ettending p tached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3	Ectopic pregna Other (specify				23d. Date Mon		y Day Year	
Records, P.	The law requires that the site has been signed by the page 2 should be detached.	þ	Part II. Other significant conditio	ns contributing to death	but not res	ulting in the u	nderlying cause	given in Part I	l. 		tobacco use contri Yes 2 □ No	bute to the		1
		• Completed	25. Was case referred to medical							1 ☐ Yes	2 310 11	ere autoprior to come eath?	sy findings availa apletion of cause of 2 No	ble of
Division of Vital	ding After funer	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	ation		ER/Outpatien 28b. Time of Injury	28c. li	211	ursing Hom		idence 6 Othe			
Ĭ O	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	ai Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of	etc. (Specif)	()	eet, factory, offi			City or To	Street and Numbe wn, State)			
	To the Hospitei within 24 hours a To the Funaral completely filled	Medical	(Check only 2 Medical E one)  29b. Signature and title of certifier	xaminer: On the basis and manner	of examina	tion and/or in	vestigation, in m	ny opinion, dea	ath occurred	d at the time,	date and place, as 29d. Date signed	nd due to	the cause(s)	
1			30. Name and address of person v	who completed cause o	The same of the sa	23a) (Type,	か」 D Print)	369	42	- 10	Augus	1 2	9,200	5
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2	All Control of the Co	oog, strar's Signa	ture	Print)  Like  Seek	Rd. (	-ppm	Jus Cle	ND 2	122	8	

	100	-	State of Ma  For State Registrar	ryland / Depa <i>Cei</i>	artment of Hertificate of E		Reg	ne No.2005	28129
y.	Physicia		1. Decedent's Name (First, Middle, Last)  RICHARD E HARD	EYER			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	, , , ,	4b. City, Town, or	Location of Death	MG	4c. County of Deat	
2.	± Annui	्। ्ं	HOWARD COUNTY HOSPITAL		COLUNA			How m	
	Funeral			(In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birt	hplace (State or Foreign buntry) t Virginia
	Director		Usual Residence of Decedent				17107171	J   W C S	
	farylar ehow	ō	10a. State 10b. County  MD Prince George	10c. City, Town or Lo Lawrel	cation				10d. Inside City Limits 11 Yes 2 □ No
	28a-1	rect	10e. Street and Number	Luwier	10f. Zip Code		10g	. Citizen of What Co	ountry?
	th with	aiD	16126 Kenny Road		2070	7		USA	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentella Hygiene. Depertment of Health and Mentella Hygiene. Depertment of Items 23a or 28a-f show important: If then 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the houldst Examination and by notified at oppose.	by Funeral Director	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent E Amed Forces? 1 Yes 2 X Not If Yes, Give Year or Dates:	2	Was Decedent of His If Yes, specify Cubar ↑ ☐ Yes 2 🛣 No	spanic Origin? (Spe h, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
Maryland 21215-0036	hin 72 hora. an "natura mo ca l	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of worki	ng	b. Kind of Business	
21	led wit lygiene her tha		12			19 Matheda Name	G (First, Middle, Ma	out. Prin	ting Ofc.
land	id be fil fentel H rked ott	To Be	17. Father's Name (First, Middle, Last) William H. Harmeyer			Mable (		oen Sumame)	
Mary	d 2 shot th and M 7 is ma traumal		19a. Informant's Name/Relationship (Type, Print) William C. Harmeyer / Broth		ng Address (Street a Wainwria				Zip Code) Land 21403
	of Heali of Heali item 2 r other		20a. Method of Disposition		esition (Name of matory or other place			c. Location - City or	
Baltimore,	tment tment tant: if		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Chesapeak	e Cremato  Name and Addres	ry 8-3	24-05 B	eltsville	, Maryland
Bal	Depending Depending Important Import		21. Signature of Fundral Service Licensee	22	7601 Sand	y Spring	Road, La	uc nome, urel, Mar	yland 20707
33			23a. Part LEnter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ent	er the mode of dying	, such as cardiac	or respiratory arrest	•	Approximate Interval Between Onset and Death
,	Physician /Medical		and the second s	CSIS					
	Examiner		PNE	MINGMU					
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	BLEET				
, 0	le be executed ysicien and e burial-transit		resulting in death) Last Due to (or as a	consequence of):					
68760,	= > =	edical	d. Di Arisi	TED 1	1601103				•
P.O. Box (	The law requires thet the death certificats ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
	w requires thet been signed b should be deta	þ	Part II. Other significant conditions contributing to death but CEUVLITIS LESS	t not resulting in the u	inderlying cause give	en in Part I.			o the cause of death?
Vital Records,		Completed					24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Dthe		h_(Check only one)		
of	Phys ral di	n: To	27. Manner of Death 28a. Date of Injur	28b. Time o			me 5 Residence 28d. Describe how	ce 6 Other (Spe	cify)
ion	Attending I r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury		Yes 2 □ No			
Division	or Attend after death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, st . (Specify)	reet, factory, office	3	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of and manner sta	examination and/or in	h occurred at the time	ne, date and place, pinion, death occurr	and due to the cau red at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier AT TENDING			56948	A	Date signed (Mont	2005
	10		30. Name and address of person who completed cause of de JAMES TANSINDA MD	eath (Item 23a) (Type.	1.1.1. 65	NEET 1	BALTIMOR	צ פט ז	1217
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2, 9 2005	r's Signature	de la				
*	ricgist	-61	AUL 2 9 2003 AMARIAN	- 1					

State of Maryland / Department of Health and Mental Hygiene 2 28130 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Physician August 22, 2005 Mary Louise Haller 8:05 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightwood Center Lutherville Baltimore If Under 1 Year 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 □ M 2 🕱 F 024-18-5507 83 Yrs December 16,1921 Massachusette Director Usual Residence of Decedent permit. Pages I and 2 should be filad within 72 hours after deeth with tha Manyland Department of Health and Mantle Itygiane. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show anyl hilpuy or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore 3 8 1 Lutherville Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 515 Brightfield Rd. 21093 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritel Status 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by white 3 Widowed 4 □ Divorced Year or Dates WWII 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Robert E. Clark Mary Elizabeth Cassens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Barbara J. Haller/daughter 4404 Manorwood Dr. Glen Arm, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/24/05 Baltimore, Maryland Greenmount Crematory 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Rd. Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical ALUTE LEUKEMIA mon THS Examiner Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that tha death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 10 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this erel Director: After thi filled in by the funerel 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a

To the Funerel C

completaly filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 1999h5 AUGUST 23 2005 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) DMINE 7505 wo TOWNUN UND 21204 OSLEN 32. Registrer's Signature 31. Date filed (Month, Dey, Year) State AUG 2 9 2005 Registrar

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 08/22/2005 2:20 William Hawthorn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Cherry Lane Nursing Center Laurel If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15 4 2□ F Hours Min. Yrs. Director 195-28-0479 04/13/1932 <u>Alabama</u> Usual Residence of Decedent the Maryland Work 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f shov the Wedical Examiner must be notified at 1 ☐ Yes 2 ☑ Ne Md Prince Georges Landover Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20706 U.S.A. 10021 Greenbelt Road Apt203 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 0 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ MO Specify: ģ 3 → Vidowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Custodian Janitorial marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) th and Mental h Be Minnie McDanial Willie James Hawthorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other treu 10021 Green Belt Road Apt 203 Donna Ayeghayeje Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/23/2005 Portland, Oregon \* 4 ☐ Donation 5 ☐ Other (Specify) Bio-Tech Anatomical 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wise Funeral Services, P.A. 700 S. Beechfield Ave Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final r nysician NOW SMALL CELL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 physician Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Ö 9 Unknown ۵. that signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ The law requires 12 Yes 2 No 3 Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 2 No 1 ☐ Yes 2 No 1 Tyes Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: ပ 1 Tes 20 No 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospitel or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenhelt Rd, Sinto 4-15, College PK MD. 20140 IKechi OKWARA 6201 32. Register's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar 28 | 32 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 8:08 P.M. SANFORD JOHNSON, AUG 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs. ST. AGNES HOSPITAL N/A8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. last birthday) 58 Yrs. Birthplace (State or Foreign Country) **Funeral** 1**X**1**X**4 2□ F Days Yrs. 250-78-4720 Director 10/21/1946 S. CAROLINA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic sysut, the Madical Examiner must be nutified at 1 Yes 2 □ No Director N/ABALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a 1556 MORELAND AVENUE 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married XXMarried ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify ģ Specify: BLACK 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Deperment of Heelth and Mental Hygiens.
Important: If itsm 27 is marked other than "na sny injury or other traumatic avent, In a Madic once. (Specify only highest grade completed) NEWINGTON SERVICES Elementary/Secondary (0-12) 12TH College (1-4or 5+) BRICK LAYER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be MOSES **JOHNSON** CAREY MAE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA JOHNSON / WIFE 1556 MORELAND AVE., BALTIMORE, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

▼ Burial 2 □ Cremation 3 □ Removal from State WOODLAWN CEMETERY 8/29/05 BALTIMORE CO., 4 Donation 5 Other (Specify) of Jugeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signatur 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Lenter the difease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) **Physician** CORONARY ARTERY UNKNOWN /Medical Due to (or as a consequence of) Examiner LIN KROWN INSUFFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed LINKIVERN DIABETES MELLITIS resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, month Certification: To Be Completed by Physician/Medical METABOLIC ENCEPHALOPATHY IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HEMICOLECTOM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? res 2 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending To the Hospitel or Attandir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PRIMART CARE DO056948 AUG. 23,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD F1515 James N. Tansinda, M.D. DOLPHIN STREET 522

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) AUG 2 9 2005

32. Registrar's Signature

Amend item// Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

The State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year JAMES 5:00 FM VIRGIL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTPELIER Cita Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 12/22 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2 F Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Nes 2 No ND Director BALT/Mone 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 940 U.S.A. Montrel items 23a Funeral Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 2 Tes 2 No U. 5 1 Never Married Married Baltimore, Maryland 21215-0036 ö If Yes, Give Year or Dates: AIR Force Completed by 1 ☐ Yes 2 ☐ ₩6 Specify: While 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRUCK CORP. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1861L . L. JAMES Dorothy ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other traione. 940 Bolto. MS Wife. JAMES MONT PELIER DUSAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 8/31/05 → Burial 2 Cremation 3 Removal from State '4 □Donation 5 □ Other (Specify) GARLISON FOREST CEM. 22. Name and Address of Facility STELLA FUNERAL HOME CHTD. 21. Signature of Funeral Service Licensee 7527 harford RD Both M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Idiopathic Physician ulmonary Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the burial-Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 No the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Xunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ate has b autopsy performed? Yes 22 No certificate 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 No this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending To the reception after death.

To the Funeral Director: After the funeral birector after the funeral birector. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10035363 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BVAMC Greene St. Ealtimore, MD 21201 Marshallus

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 9 2005

Speck

2. Registrar's Signature

			1 - State Registrar	ate of Maryland /	Department of H Certificate of L	ealth and Me D <i>eath</i>	ental Hygie Reg	ene 2005	28131
	المادة		Decedent's Name (First, Middle, Last)				2. Date of Death	_	3. Time of Death
	Physicia /Medid		William George Kalis				August	23, 2005	8:35P ™
	Examin	er	4a. Facility Name (If not institution, give street 4709 Coastal Hwy.,	<sub>and number)</sub> Jnit 260	4b. City, Town, or Ocean Ci	Location of Death		4c. County of Death Worcester	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last I	birthday) If Under 1 Year				lace (State or Foreign
	Director		220-05-0797 <b>X</b> ₩ <sup>3</sup>	<sup>□</sup> F 84	Yrs. Months Days	Hours Min. D	B. Date of Birth (Month, Day, Yo ecember 8,	1920 Mary	Tand
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			1	0d. Inside City Limits
	Mary I sho	tor	Maryland Worcester	0cean	City				1√√Yes 2 □ No
	th the or 28e	irec	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cour	ntry?
	ath wi	ral	4709 Coastal Highway		2184			USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumetic event, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married	as Decedent Ever in U.S. med Forces? MYes 2 □ No WWII Yes, Give ear or Dates:	13. Was Decedent of Hilf Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: Wh	
2-0	72 ho "natur dical	Completed	15. Decedent's Education (Specify only highest grade com		ia. Decedent's Usual Occupa (Give kind of work done d	uring most of working	16	b. Kind of Business/In-	dustry
121	within ene. then "	ldmo	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	Salesperson	)	Т	ndustrial	Supply
	e filed within al Hygiene. I other then vent, the We	Be Co	17. Father's Name (First, Middle, Last)		ou respension	18. Mother's Name	First, Middle, Mai	iden Surname)	Suppry
ylar	should be nd Mental marked c	To B	Joseph Michael Kalis	ta		Florenc	e Geisen	doeffer	
Maryland	12 sho n and 7 is mu reum		19a. Informant's Name/Relationship ( <i>Type, Pi</i> William G Kalista Jr	- Fi	9b. Mailing Address (Street a				
	Health Health tem 27		20a. Method of Disposition	20b. Place	2802 Gent Roa of Disposition (Name of	Da		c. Location - City or To	
ē	Pages nent of I ont: If it		1 A Burial 2 ☐ Cremation 3 ☐ Remov	armom State	tery, crematory or other place / Valley Mem Garc		05 T	imonium Ma	ryland
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		21 Signature of Funeral Service Licensee	Venak	22. Name and Addres		nell-Wiede		Home Inc
	j.		23a. Part1. Enter the disease, o complication shock, or heart failure. List only one cau	s that caused the death. Do	o not enter the mode of dying	, such as cardiac or	respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	L-ng C	enomo				Onset and Death
	/Medical Examiner			Due to (or as a donsequenc	e of):				
		Jer	Sequentially list conditions.  I any, loading to inmediate cause. Enter Underlying.	Die to (or as a consequenc	3·0f):				
	iicate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
60,	be ex ician a burial		Tooding in doding state	Due to (or as a consequenc	e or):			1	
68760,		edical	d		777777				
P.O. Box	that the death certificed by the attending detached for use as	Physician/M	in the past 12 months?	yes, outcome of pregnancy  Live birth	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of delive Month	ny Day Year
	law requires that the as been signed by th 2 should be detache	by Pr	Part II. Other significant conditions contribut	ng to death but not resulting	in the underlying cause give	n in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
Zd	w require been sig should b						1 🗆 Yes	2 □ No 3 □ Prob	ably 4 <del>∃Unk</del> nown
Vital Records,	e law r has be je 2 sh	Completed					24a. Was an autopsy performed	prior to cor	osy findings available inpletion of cause of
<u>a</u>	Th ate pag		OF Western State and State				1□ Yes 2□		2 1 No
	0 O	o Be	25. Was case referred to medical examiner?  1 Yes 2 Ho Hospita	al: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 DOA Othe	26. Place of Death		e 6 Other (Specify	· · · · · · · · · · · · · · · · · · ·
n of	ding Phy I. After thi funeral	atlon: T	27. Mann of Death 1 Natural 5 Pending		. Time of 28c. Injury Injury Work		d. Describe how		7
Division	Attending or death. ector: After by the fune	icatl	2 Accident investigation	Disco of laine. At hama		′es 2 □ No	of Lagation (Street	t and Number or Rura	I Davis Number
D	al or Attences after death	ertifica	4 Homicide determined	<ul> <li>Place of Injury - At home, building, etc. (Specify)</li> </ul>	rarm, street, ractory, office	20	City or Town, S		r Houle Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edical C	(Check only 2 Medical Examiner: C	To the best of my knowled in the basis of examination and manner stated.	ge, death occurred at the tim and/or investigation, in my op	e, date and place, ar inion, death occurred	d due to the caus d at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0-	29c. License	number	29d.	Date signed (Month, I	Day, Year)
	ar.		) The Os		145	1718		812412	8
	1 (0 )		30. Name and address of erson who complet Joseph McShea, M		cetrack Rd.,	Berlin M	d. 21811		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		20111119 11	~. LIOII		
10.	Registr	ar	AUG 2 9 2005	Mague 1	South				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** ,2005 AUGUST AMMA 1-10-1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Northwest Hospital Center Baltimore Randallstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛱 F Months 89 April 23,1916 Maryland Director 216-12-5413 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10h. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Eldersburg Maryland Carrol1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21784 2000 C Rudy Serra Drive death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Seamstress Clothing 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Josephine Costellani Vincent Valianti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Sykesville, Maryland 21784 4000 Robin Hood Way Dolores Morseberger (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-31-2005 Baltimore, Maryland New Cathedral Cem. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COLITIES DIFFIULLE CSTRIDIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Decupitus that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached to 1 Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 25 No 1 Tes : After this certifica e funeral director, r or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 25 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 | Homicide within 24 hours a filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 D0041410 August JOHINDERP MEHTA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JATIPIOH CENTER RAMORUSTOWN MORTHWEST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2005 Registrar

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f ehow

the Medical Examiner must be notified at

"natural", or Iteme 23a

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2.1
Department of Health at Important: If item 27 is any injury or other trau

Physician /Medical

Examiner

Directo

ð

Completed

with the Maryland

hours after

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year W9 10:00 PM REVAR 25 2005 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 1405PITAL 23MPA ST. BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign County)

ARt IN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2□ F Months Days 245-44-0846 Usual Residence of Decedent Yrs. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Pres 2 No MORE Ma 10g. Citizen of What Country? 10e. Street and Number 2446 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 12 Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 Married 1 Never Married 1 ☐ Yes 2 ☑ No 565 Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) c Coll EWISM uch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, P o) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12005 4 □ Donation 5 □ Other (Specify) Em 21. Signature of Funeral Service Licensee Name and Address of Faculty DALTO DADWAY 23a. Part1. Enter the disease, or complications that pused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCITOPENIA DATS Due to (or as a consequence of) monTHS YMPHOMA Securations is any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MALNUTRITION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident

Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical ed by the detached ate has been signed by page 2 should be detack ģ Completed certificate director, Be ို After this funeral dir Certification: Director: /

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 🗌 Suicide

4 Homicide

4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number 00059190

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month. Dav. Year) AUG 25 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOMNIE BAFFOE-

57. AGINES HOSPITAL, BALTIMORE

State Registrar

31. Date filed (Month, Day, Year) AUG 2 9 2005

6 Could not be

32. Registrar's Signature

in 24 hours. the Funeral Dire

within 24 ho To the Func

To the

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** August 2005 1:35 June Verna Mallory /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel Millennium Health Care If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 X F Yrs. June 9, 1927 Washington, D.C. Director 78 577-34-1504 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. Counts 10a State th and Menial Hygiene. ?7 is marked othar than "natural", or Itams 23a or 28a-1 show traumatic avant, the Medical Exat. a er must be ricitlied at 1 ☐ Yes 2√ No Maryland Anne Arundel Glen Burnie Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 808 Bent Willow Drive 21061 United States by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced If Yes, Give \*\* Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Olga Harper George Reier 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other traionce. Olga Mallory / Daughter 808 Bent Willow Drive Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 Brentwood, Maryland \* 4 □Donation 5 □ Other (Specify) Fort Lincoln Cem. 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 21. Signature of Funeral Service Licensee Dav 421 Crain Hwy. S.E. Glen Burnie, MD 21061 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Onset and Death Sudiac Immediate Cause (Final tory/toma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter of 35 Mg Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Minknown LINUL 1a Be Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 No certificate 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 Mo Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of After 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Diractor: A 6 □ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) e of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) opram.D. 600R 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

AUG 2 9 2005

			1 - State Registrar	aryland / Depa	artment of Heartificate of De		Reg	ene 1. No. 2005	28138
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Ruby J. Morrison				2. Date of Death Month August 2	4, 2005 Year	3. Time of Death 12:30 A.M
	Examir		4a. Facility Name (If not institution, give street and number, 550 LaCosta Circle Apt.		4b. City, Town, or Low Westminster			4c. County of Death	
	Funeral Director		272-28-2160 ¹□м 2∏F	ge (In yrs. last birthday) 73 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) NOV • 21,	9. Birth	nplace (State or Foreign Intry) Lrginia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Wadral Examiner rust be notified at ODGs.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Carroll County  10e. Street and Number  550 LaCosta Circle Apt. 1  11. Marital Status  1	16a Dece   Give   16a Dece   Give   ife.   Admin   550   West   20b. Place of Dispocementery, crecementery, crec	10f. Zip Code   21158     Was Decedent of Hispa     If Yes, specify Cuban, N     Yes 2 N   No   S     In Yes 2 N   No   N     In Yes 2 N   N     In	anic Origin? (Spe Mexican, Puerto f Specify:  In most of workin  Mother's Name  Lova Aco  Number or Rura  rcle  21158  Augus  Augus  11268 Fundary	city Yes or No-Rican, etc.)  16  M (First, Middle, March 103  Apt. 103  ate 29, 05  cral Hom	g. Citizen of What Confirmed Stat  14. Race - American Black, White Specify: Will  Sb. Kind of Business/Indian Sumame)  City or Town, State, Zoc. Location - City or Tatonsville  P.A.	10d. Inside City Limits  1 □ Yes 2 No untry?  Les ican Indian, o, etc. hite ip Code)  Town, State
Box 68760,	The law requires that the death certificate be executed a point of the attending physician and a page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   IF FEMALE:  23b. Was decedent pregnant in the past 12 mopths?	a consequence of):  a consequence of):  a consequence of):	Ectopic pregnancy	LAR	LEUK	EMM  23d. Date of deline	Very Day Year
ds, P.O.	ires that the de signed by the a d be detached t	by	1 Yes 2 Two 9 Unknown 9 Unknown  Part II. Dther significant conditions contributing to death			n Part I.	23e. Did toba	cco use contribute to	the cause of death?
Il Records,		Completed					24a. Was an autopsy performe	24b. Were aut prior to death?	opsy findings available ompletion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital:		Other	6. Place of Death	(Check only one)		
of	ding Phy h. After this funeral d	tion: To	1 Yes 2 No Hospital: 1 Inpati 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ent 2 ER/Outpatier ury 28b. Time o Injury	f 28c. Injury at Work?	4 Nursing Hom	ne 5 President 8d. Describe how	ce 6 ☐ Other (Specinjury occurred	ify)
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of In	jury - At home, farm, sti tc. (Specify)	reet, factory, office	2	8f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (	29a. Certifier (Check only one)  1 Certifying Physicien: To the besis and manner s	of examination and/or in	h occurred at the time, ovestigation, in my opinion	date and place, a on, death occurre	nd due to the cau d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To ti To ti comp	Ž	29b. Signature and title of certifie	MD	D 35	398 398	290	Date signed (Month	Day, Year)
	19		30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	toust	er. MD	21157	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	e e				

			For State Registrar	State of Maryland / [	Department of Health a Certificate of Death	and Mental Hygie	Z11115 28130
	Physic /Medi		1. Decedent's Name (First, Middle, Las Henry Means			2. Date of Death AMonth AUGUST	Day 8, 2005 110 AM
	Examir		4a. Facility Name (If not institution, give Gilchrist Cente	r for Hospia Ca			4c. County of Death Bultmore
¥	Funeral Director		5. Social Security Number 6. Se 11  3.448-48-1674 11  Usual Residence of Decedent	74.00= 70	thday) If Under 1 Year If Under 1 Year Yrs. Months Days Hours	Min. State of Birth Month, Day, Ye	9. Birthplace (State or Foreign Country) 1932 South Carolina
	Maryland f ehow filed et	tor	10a. State 10b. County  Mary Land N/A	10c. City, Town	finore		10d. Inside City Limits 1
	h with the 23a or 28a	Funeral Director	100. Street and Number 2629 Bergl	Avenue	10f. Zip Code 2/205	10g.	citizen of What Country? United States
036	hours after death with the Maryland turel', or Items 23a or 28a-f show al Exartante must be invitited at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ' Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican 1 Yes 2 No Specify:	in? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	within 72 ane. then "nar	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	Self-Employed
Maryland 2	ould be fited Mental Hyginarked other	To Be C	17. Father's Name (First, Middle, Last) Henry Mean	s, Sr.	18. Mothe	r's Name (First, Middle, Mai GNOLIA P. P	den Sumame) 20 ples
In.	s 1 and 2 should if Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship (7 Trmb Means - 1	Vife 2	Mailing Address (Street and Number L 29 Bergl Ave	rue Balti	more, Maryland 21205
Baltimore	permit. Pages 1 Department of H Important: If Ite any injury or otl		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State  Little	River Pres. Church	2005 F	Location - City or Town, State  Lair, South Carolina
Bal	permi Depa Impo any ir	1000	21. Signature of Funeral Service Licen-	with the		saltmore, M	arbland 21229
	Physician /Medical Examiner	e i	23a. Part1. Enter the disease, or compositions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	one cause on each line.	tic gastic car		Approximate Interval Between Onset and Death
8760, 6	frate be executed physicien and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to intrindiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of d.	· 		
Box 6	The law requires that the death certifica ate has been signed by the attending pr page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P.O	quires that n signed b uld be deta	þ	Part II. Other significant conditions of	ontributing to death but not resulting in			co use contribute to the cause of death?  2 ☑No 3 ☐ Probably 4 ☐Unknown
Division of Vital Records,	The law require ate has been sig page 2 should b	Completed	itypertension	•		24a. Was an autopsy performed 1 Yes 2 🕅	
f Vita	Physiclan: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Othor	of Death Check only one	6 ©Other (Specify) \$ 05 Pice
ion o	fler fler	ertification:	27. Manner of Death 1   Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	ime of a plury at Work?  M 28c. Injury at Work?	28d. Describe how in	
Divis	tal or Atters after de al Directo	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	dicai	one) 2 Medical Exam	vsician: To the best of my knowledge iner: On the basis of examination and manner stated.	d/or investigation, in my opinion, deat	h occurred at the time, date	and place, and due to the cause(s)
)	To To t	Σ	29b. Signature and title of certifier  Anthony	lily ins	29c. License number	29d.	Date signed (Month, Day, Year)
	<i>\</i>		30. Name and address of person who did it is the same and address	completed cause of death (Item 23a) (	Type. Print) Charles St. Bal	to My 2120	Date signed (Month, Day, Year)
か ながれ	Sta Registi	ite ar	31. Date filed (Month, Day, Year)  AUG 2 9 2005	32. Registrar's Signature	ede .		

<b></b>		1 - For State Registrar  1. Decedent's Name (First, Middle, Last	State of Maryland	/ Depa		lealth and	Mental Hyg	giene	2814
Physici	an	Decedent's Name (First, Middle, Last)	Virginie B. M	0000				17, 2005 Year	7:46 p.
/Medic Examir		4a. Facility Name (If not institution, give Howard County Gene	street and number)	0363	4b. City, Town, o	r Location of Deat		4c. County of Death	)
Funeral Director		5. Social Security Number 6. Se 116-07-8814		t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth Month, Day Septemi		place (State or Foreir
Maryland I-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Ho	10c. City, 1	Town or Lo		Columbia			10d. Inside City Limit 1 ☐ Yes 2 N
with the	Director	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What Cou	untry?
a 23c	erai	10205 Wincopin Circle	#304 12. Was Decedent Ever in U.S.	12	Was Decoded of H	21044	positu Van ar Na	U.S.A.	ican Indian
n 72 hours efter death with the Maryland "natural", or Itema 23a or 28a-f show adical Examirer must be notified at	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛛 No	Specify:	o Rican, etc.)	Black, White	
within 72 ho ene. than "naturi he Medical	pieted	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	16b. Kind of Business/li	ndustry tration
d with	E	Elementary/Secondary (0-12)	4+		Commercia	l Artist / Illus	trator	ilius	iration
al Hygie d other event, it	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, I	Maiden Sumame)	
should be nd Mental marked o	To E		erritt Berger				<del></del>	Tirell de la Martir	
d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (T)	rpe, Print)					r, City or Town, State, Zi	ip Code)
s 1 end if Heeith Item 27 other t		Ms. Lucie Lynch	Neice Neice		7129 Rivers V	/iew Ct. Colu	-		
8 = 5		20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ F	Removal from State	etery, cre	matory or other plac			20c. Location - City or T	
permit. Pag Department Important: any Injury o		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licepa  23a. Part1. Enter the disease, or comp	All Co	2	remation Ser 2. Name and Addre Slack	ss of Facility			, Maryland
Physician // Medical Examiner parial-transit	cai Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent to to to (or as a consequent to to consequent to the consequent	nce of):	Cartion	iascula	y Dis	easl	Interval Between Onset and Death
a ettending pl	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deat	eath 3	Ectopic pregnancy Other (specify)	,		23d. Date of deliving Month	/ery Day Year
ures that the de signed by the e id be datached f		Part II. Other significant conditions co	ntributing to death but not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did tot	bacco use contribute to	the cause of death?
ican: The law requires that the certificete has been signed by the rector, page 2 should be datache	Completed							prior to co death? No 1 Yes	opsy findings availal ompletion of cause of 2 No
Physician: this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Dth		th Check only on		
ع والع	ition; To	1 XYes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	VOutpatie Bb. Time o Injury	f 28c. Injun Wor	y at		ence 6 □Other (Speci ow injury occurred	rfy)
is of Attenditions after death.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, st	reet, factory, office		28f. Location (St City or Town	treet and Number or Rur n, State)	ral Route Number,
Hospii 4 hour Funeri ely fills	Medical	2.ta Certifus 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the best of my knowled and manner stated.	adge, daat n and/or in	r occurred at the til vestigation, in my o	na, data and place pinion, death occu	, and due to the co irred at the time, d	ause(s) and manner as ate and place, and due t	stateu. to the cause(s)
To the I within 2 To the I complete	Σ	29b. Signature and title of dentifier	/M		29c. Licens OCM		2	9d. Date signed (Month, August 19,	
T		30. Name and address of person who co	AN			n Street	Baltimo	ore, Marylar	nd 21201
Sta Regist		31. Date filed (Month, Day, Year)	32. Registral's Signatur	9	South !			-	

		ļ	1 - For State Registrar	State of	Maryland	•	artment of H			, ,	giene Rog. No.	יחחל	- 0011
8	Physici	an	1. Decedent's Name (First, Middle,		Jarin					2. Date of Dea Month	ith Day	Year	3. fine Death
	/Media		Mury B  4a. Facility Name (If not institution,				4b. City, Town, o	r Location	of Dooth	8	34	County of Deat	
7-	Examir	er				hal	40. City, rown, o	Location		umbia	40.		oward
	- Funeral	3000		rd County Gen	ierai Hospii . Age (In yrs. ias		If Under 1 Year	If Under		8. Date of Birtl	h	9. Birt	hplace (State or Foreign
746	Funeral Director		189-12-3876	1□M 2 <b>X</b> F	83		Months Days	Hours	Min.	(Month, Day	, Year)	Co	untry)
	ъ		Usual Residence of Decedent	1						January 2	0, 192	2 1	Pennsylvania
	how		10a. State 10b. County		10c. City,	Town or Lo	ocation						10d. Inside City Limits
	e Ma	cto	Maryland	Howard			E	Ilicott C	ity				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	· ·
	d within 72 hours atter deeth with the Maryland Jene. r than "natural", or items 23s or 28s-1 show the Medical Evar it artifual be troilled at		3602 Underoak						042			U.	S.A.
	tems	Funeral	11. Marital Status	Armed Ford		. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Or an, Mexica	igin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	1	<ol> <li>Race - Ame Black, White</li> </ol>	
36	s atte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give			1□Yes 2₺No	Specify:				Specify:	White
8	hour turai'	d b	15. Decedent's	Year or Dat		16a D	dania Haral Oarra	-4!		,	405 165	d -4 B	
5	n 72	Completed	(Specify only highest	grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during mos	t of workii	ng	IOD. KIII	id of Business/ Art E	ducation
12	within iene. then "	mo	Elementary/Secondary (0-12)	Coflege (1-4	for 5+)			reacher	-			\(\(\)(\)	ducation
0	Hyge Hyg	a	17. Father's Name (First, Middle, L	ast)				18. Moth	er's Name	(First, Middle,	Maiden S	Sumame)	
lan	0 0 0 0 0	To B	Wi	lliam Burns							Ethel	Lash	
Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Refationshi			19b. Maili	ng Address (Street	and Numb	er or Rura	l Route Numbe	r, City or	Town, State, 2	Zip Code)
	1 and 2 Health a tem 27 is		Ms. Wendy A. Les	sles Dau	ughter		10040 Waterl	ford Dr.	Ellicot	t City, Man	yland 2	21042	
<u>5</u>	of Head of Head fitem r othe		20a. Method of Disposition	- PE-1	20b. Pla	ce of Disper	osition (Name of matory or other place	ng)	D	ate	20c. Loc	ation - City or	Town, State
Ë	Pages nent of I int: if it		1 Durit 2 Cremation 3		tate		John's Cemet	1	08/	25/2005		Ellicott	City, MD
Baltimore,	permit. Pages Depertment of Important: If i any injury or o		21. Sign ture of Fyrieral Service L	сеу ее			2. Name and Addre		ty				
m	88 4 8	1.0	Membellen /	Ull 1	200535	-	Slack	Funeral	Home	, P.A. Pike Ellicot	t City	MD 2104	3
- %			23 Part 1. Enter the disease, or o shock, or heart failure. List of	omplications that can	used the death.	Do not en	ter the mode of dyin	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
100	Pnysician		I nmediate Cause (Final disease or condition				yploma						Onset and Dath
	/Medical		resulting in death)		r as a conseque		4 (10.11)						/ Mental
4	Examiner		Sequentially list conditions,	b									
	D #	ner	if any, feading to immediate cause. Enter Underlying	Due to (o	r as a conseque	ence of):							
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	cate be executed physicien and the burial-transit		iosaling in acatily sact	Due to (o	r as a conseque	ence or):							
87		dicai		d	-				-				
9 ×	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. ff yes, outco	ome of pregnance	cv							
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1☐Live bir	th 2 Fetal o	death 3[	☐Ectopic pregnancy ☐ Other (specify)	/			2	3d. Date of del Month	Day Year
0	that the de led by the a detached t	ysic	1 □ Yes 2 ☑No 9 □ Unknown	9□ Unknov		XIII 31	Other (specify)						
<u>a</u>	that led by deta		Part II. Other significant condition	s contributing to dea	ith but not result	ting in the u	inderlying cause giv	en in Part	l.	23e. Did to	bacco us	se contribute to	the cause of death?
sp.	uires sign ld be	d by	Animin	osteop	cresis					1 🗆 Y	es 2	Mo 3□Pr	obably 4 DUnknown
00	w requir been si should	Completed	Anorixia -	Carkex	16					24a. Was	an	24b. Were au	itopsy findings available
Re	The law cete has page 2 :	E				_				autop	sy rmed?	prior to death?	completion of cause of
B		e C	25. Was case referred to medical					20 Dia a	a of Dooth	1 Yes	2 No	1 ∐ Yes	2 No
5	Physicien: this certifical	0 8	examiner?	Hospital: 1 Nn	patient 2□E	R/Outpatie	nt 3□ DOA Oth	er		n <i>(Check only o</i> me 5 □ Resid		Other (See	out ()
o		<b>-</b>	27. Manner of Death	28a. Date of	Injury 2	28b. Time o	of 28c. Injur	v at		28d. Describe h			спу)
ion	Aft.	atio	1 Natural 5 Pending 2 Accident investiga		, Day Year)	fnjury	M 1 🗆	rk? Yes 2.⊑	No				
Division of Vital Records,	or Attanding siter death. Director: After in by the fune	III C	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of			reet, factory, office		- 1				ural Route Number,
ā	To the Hospital or Attandi within 24 hours efter death To the Funerel Director: A completely filled in by the fi	Certification:		Odildin	g, etc. (Specify)					City or Tow	, JIE18)		
	ospit hour uner ly fille		29a. Certifier Certifying	Physician: To the t	est of my know	ledge, dea	th occurred at the tir	me, date a	nd place, a	and due to the	cause(s)	and manner as	stated.
	To the Hospital within 24 hours To the Funerel	ledical	one)	xaminer: On the bas and manne	er stated.	and/or if			aus OCCUTT				
	Vith To 1	Σ	29b. Signature and title of certifier				29c. Licens		. 2			signed (Mont	
•	~		you M.	mll				305-	1 )		8	-24-0	5
1	0		30. Name and apdress of person w		of death (Item 2	23а) (Туре	Print)	, ,	\ .	10	1.		
1				コカテータ				P Pa	TOXC	ny rai	- Kwa	14,60	lumbia MD
	St	ate	31. Date filed (Month, Day, Year)		gistrar's Signatu	Ire	Tours!						21044

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 24, 11:03amM JAMES LEE MORGAN SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GILCREST HOSPICE CENTER TOWSON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1-3-1923 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 1 F Director 230-28-4007 82 Yrs. VĬŔĠĬŊĬĄ Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28e-f ehow The Medical Examiner must be notified at MD. N/A BALTIMORE 1 No 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 WINDSOR GARDEN LANE 21207 USA e filed within 72 hours after death in Hygiene.

other than "natural", or terms 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Maritaf Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No BLACK þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -6--0-LABORER CONSTRUCTION .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if item 27 is marked other t ilury or other traumatic event, ID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS MORGAN MARY ROSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Print) MARY MORGAN (WIFE) 2121 WINDSOR GARDEN LANE BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispositio 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department o Important: if eny injury or once. ARBUTUS MEMORIAL PARK 8-29-2005 BALTIMORE, MARYLAND 5 (Specify) JONATHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE af Service Licenses 21. Signature of 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Interval Between Immediate Oduse (Final disease or condition resulting in death) Onset and Death congestiv **Physician** ears /Medical Due to (or as a consequence of): Examiner MO' Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical fF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the inector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown VASEL CAN disense 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Hospitaf: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred CertIfication: 28c. fnjury at Work? 1 Natural fnfury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tille of gertifier 29c. License number un ted cause of death (ftem 23a) (Type, Print) 30. Name and address of person who comple Charles St. 32. Restrar's Signature State 2005 9

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	tate of Maryland	-			lental Hygie	ene . No. 200	5 2814
	Dhysisi	a	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio			CHARLES GIL	BERT M	UHLER			23, 2005	1:15 p M
	Examir	er	4a. Facility Name (If not institution, give stree	et and number)		4b. City, Town, or	Location of Death		4c. County of Dear	
			215 Belmont Forest 5. Social Security Number 6. Sex		-4 6 (-6 -4 - 1)	Timoni	um If Under 24 Hrs.			ce County
	Funeral Director		579-18-8790 XXM	7. Age (In yrs. la 2□ F 82	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		thplace (State or Foreign ountry)
	ow ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	a-f sh	tor	MD Baltimore	e Timo	onium					1 ☐ Yes 2XXXNo
	or 28	Dire	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	s 23s	rai	215 Belmont Forest			2109			USA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Evantment must be redified at once.	by Funeral Director	1 Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	1	as Decedent of His Yes, specify Cuban □Yes 2\X\ No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	e, etc.
2-0	72 ho 'natur dicel	eted	15. Decedent's Education (Specify only highest grade co		16a. Decede	ent's Usual Occupation of work done du	tion urina most of worki	na 16	b. Kind of Business/	Industry
121	within ane. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	'life. D	ind of work done du O NOT use retired)	<b>.</b>			
d 2	filed Hygie		12 17. Father's Name (First, Middle, Last)			Sales	18. Mother's Name	(First, Middle, Ma	Manufact	uring
<u>lan</u>	uld be Jental rked c	To Be	Edv	vard Gottliel	Muhle	er	Kat	herine Ch	ristine 0	Gail
lary	2 short		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing	Address (Street ar	nd Number or Rura	l Route Number, C	ity or Town, State, 2	Zip Code)
Baltimore, N	ges 1 and it of Health If Item 27 or othar tr		Mrs. Barbara Muhler  20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Remo	20b. Pla cer	nce of Dispos metery, crema	tion (Name of atory or other place	)	ate 20	1 Timoniu	Town, State
턡	it. Pa rtmen rtant: njury		`4 □Donation 5 □Other (Specify)	Dular					keysville	
Ba	Depa Impo any la		21. Signature of Funeral Service Licensee	/AL	650	00 York R	oad, Bal	timore, M	ome, Inc. D 21212	
	Physician		23a Art1. Enter the disease, or complication of the complex to the comp	ons that caused the death.	_	the mode of dying,	such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque		adder	Cano			Month
	- Zanimici	0	Sequentially list conditions, b	Due to (or as a conseque	ance of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(c. uo u cosoque						
oʻ	an and rial-tra		resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	cate be executed physician and the burial-transit	dicai	d							
P.O. Box 6	The law requires that the death certificate be executed tae has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	f yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	leath 3 □E	ctopic pregnancy Other (specify)			23d. Date of deli	very Day Year
٣.	res that I	by Ph	Part II. Dther significant conditions contributions	uting to death but not result	ing in the unc	lerlying cause giver	in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	w require: been sig should b							1 ☐ Yes	2 □ No 3 □ Pro	Obably Unknown
		Completed						24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of
Vita	Attending Physician: Ther death.  sector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	ital			26. Place of Death	(Check only one)		
	S S	. To	1 105 21 10	1 □ Inpatient 2 □ El	R/Outpatient 8b. Time of		4   Nursing Hon	ne 5 Residence 8d. Describe how i	e 6 Other (Spec	ify)
on	nding th. : After s fune	tlon	1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year)	Injury	28c. Injury a Work? M 1 Ye	es 2 No	od. Describe now	njur <b>y</b> occurred	
Ź	Patric	Certification:	3 Suicide 6 Could not be	8e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	et, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	Z INGOICAI LAAITIITEI.	n: To the best of my knowl On the basis of examinatio and manner stated.	edge, death on and/or inve	occurred at the time stigation, in my opin	, date and place, a nion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	296. Signature and title dicertifier	DNC OLOG	IST	29c. License	number	29d.	Date signed (Month	
	9		Mary		10-1/7		569	17 0	8/24	105
/	0		30. Name and address of person who content	Donega	~		05,6569 N	.Charles	St.Balto	.MD 21204
7	Sta Registr		AUG 2 9 2005	32. Angistrar's Signatur		whe				

Funeral Director    Funeral Director   S. Social Security Number   S. Secial Security Number   S. Social Security Number   S. Secial Security Number   Secondary Secondary   Secondary   Secondary Secondary   S	9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limit 1 Yes X No
Examiner  4a. Facility Name (If not institution, give street and number)  Creare Marimo Le Medical  Funeral  Director  Funeral	9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limit  1  Yes X No  Zen of Whal Country?  ted States  14. Race - American Indian, Black, White, etc.  Specify: White  Ind of Business/Industry  Town, State, Zip Code)  Maryland 21146  cation - City or Town, State  altimore, Maryland  dalk, Inc.  1 and 21222  Approximate Interval Between Onset and Death
Social Security Number   2.17 - 20 - 7725   1   M 2   St   F   79   Yrs   Months   Days   Hours   Min.   Month, Day, Year)   July 9, 1926   100. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10b. Sireet and Number   21.224   Unit   10b. Sir	9. Birthplace (State or Foreig Country)  Maryland  10d. Inside City Limit  1  Yes X Note of States  14. Race - American Indian, Black, White, etc.  Specify: White and of Business/Industry  Town, State, Zip Code)  Maryland 21146  cation - City or Town, State  altimore, Maryland  dalk, Inc. 1 and 21222  Approximate Interval Between Onset and Death
The content of the	and Maryland    10d. Inside City Limit     1   Yes X⊠N     2en of Whal Country?     ted States     14. Race - American Indian, Black, White, etc.     Specify: White     md of Business/Industry     home     Town, State, Zip Code     maryland 21146     cation - City or Town, State     altimore, Maryland     dalk, Inc.     1222     Approximate     Interval Between     Onset and Death
Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimore  Colgate  10c. City. Town or Location  Maryland  Baltimore  T1.35 East Baltimore Street  11. Marital Status  1   Never Married 2   Marned  12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-Niry Section)   12   14   15   15   15   16   16   16   16   16	altimore, Maryland  altimore, Maryland  dalk, Inc.  21222  Approximate  Ind Naside City Limit  1 □ Yes X⊠Ni  1 □ Yes X⊠Ni  2 ■ X∭Ni  3 ■ X∭Ni  3 ■ X∭Ni  4 ■ X∭Ni  4 ■ X∭Ni  5 ■ X∭Ni  6 ■ X∭Ni  6 ■ X∭Ni  7 ■ X∭Ni  8 ■ X∭Ni 8 ■
10a. State   10b. County   10c. City, Town or Location	ted States  14. Race - American Indian, Black, White, etc.  Specify: White and of Business/Industry  Town, State, Zip Code)  Maryland 21146  cation - City or Town, State  altimore, Maryland dalk, Inc. land 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ted States  14. Race - American Indian, Black, White, etc.  Specify: White Ind of Business/Industry  Town, State, Zip Code)  Maryland 21146  Cation - City or Town, State  altimore, Maryland  dalk, Inc. Land 21222  Approximate Interval Between Onset and Death
23a. Parri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	ted States  14. Race - American Indian, Black, White, etc.  Specify: White Ind of Business/Industry  In Home Sumame)  17 Town, State, Zip Code)  Maryland 21146  Cation - City or Town, State  altimore, Maryland  dalk, Inc. 1 and 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A UNITY OF CANCER  Due to (or as a consequence of):	14. Race - American Indian, Black, White, etc.  Specify: White and of Business/Industry  Town, State, Zip Code) Maryland 21146 cation - City or Town, State altimore, Marylan  dalk, Inc. 1 and 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Black, White, etc.  Specify: White Ind of Business/Industry  The Home Sumame)  Town, State, Zip Code)  Maryland 21146  Cation - City or Town, State  altimore, Marylan  dalk, Inc. land 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	White  Ind of Business/Industry  In Home Sumame)  In Town, State, Zip Code)  In Maryland 21146  Ication - City or Town, State  altimore, Maryland  dalk, Inc. Indiana 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	n Home Sumame)  r Town, State, Zip Code) , Maryland 21146 cation - City or Town, State altimore, Marylan dalk, Inc. land 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Sumame)  r Town, State, Zip Code)  , Maryland 21146 cation - City or Town, State altimore, Marylan  dalk, Inc. land 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Sumame)  r Town, State, Zip Code)  , Maryland 21146 cation - City or Town, State altimore, Marylan  dalk, Inc. land 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	r Town, State, Zip Code)  , Maryland 21146  cation - City or Town, State  altimore, Marylan  dalk, Inc. land 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	, Maryland 21146 cation - City or Town, State  altimore, Marylan  dalk, Inc. land 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	, Maryland 21146 cation - City or Town, State  altimore, Marylan  dalk, Inc. land 21222  Approximate Interval Between Onset and Death
23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	cation - City or Town, State  altimore, Marylar  dalk, Inc. land 21222  Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	dalk Inc. land 21222 Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Authorized Caucer  Due to (or as a consequence of):	dalk Inc. land 21222 Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Approximate Interval Between Onset and Death
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A UNITY OF CANCER  Due to (or as a consequence of):	Approximate Interval Between Onset and Death
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	Onset and Death
resulting in death)  Due to (or as a consequence of):	Monis
iner in the state of the state	
if any, leading to immediate Due to (or as a consequence of):	
that initiated events c.	
resulting in death) Last  Due to (or as a consequence of):	
d	
IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
230. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy  in the past 12 profits?  4 Pregnant at time of death 5 Other (specify)	Month Day Year
1 Yes 2 Who 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco u	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	use contribute to the cause of death?
1 Yes 2	□No 3 □ Probably 4 Unknow
24a. Was an autopsy performed? 1 Yes 27 No	24b. Were autopsy findings availa prior to completion of cause of
autopsy performed?	death?
5 0 25. Was case referred to medical 26. Place of Death (Check only one)	
examiner? O 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	6 □Other (Specify)
	ry occurred
To 2 Accident investigation  2 Accident investigation  3 Suicide 6 Could not be  3 Suicide 6 Could not be	
4 Homicide determined determined determined 268. Place of injuty of interior injuty of interior injuty of	nd Number or Rural Route Number, a)
Ö	\
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date of the control of the cause (s) of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.	
29b. Signature and title of certifier 29c. License number 29d. Dat	te signed (Month, Day, Year)
DS8303 AUG	UST 23 2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	UST 23 2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	croy
State Registrar 31. Date filed (Month Pay Year) 2005	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 23, 2005 **Physician** Jack Gustav Palmer 6:50 a. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Elkridge 6189 Meadowridge Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 1 X M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs 73 Director 219.28.9252 October 28, 1931 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show 1 ☐ Yes 2 No Funeral Director Elkridge Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21075 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Madical Exactional 1990. 6189 Meadowridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give F Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hydraulics Elementary/Secondary (0-12) College (1-4or 5+) Mechanic unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura Hare Judson M. Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6189 Meadowridge Road Elkridge, Maryland 21075 Spouse Ms. Nadine Palmer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Columbia, MD 4 □ Donation 5 □ Other (Specify) St. John's Lutheran Church 😂 🕽 🕟 💍 22 Termetet Address of Facility 21. Signature of Funeral Service Licenses Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Enter the deease or complications that caused the deeth. Approximate Interval Between Onset and Death 23a. Part1 Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Chronic Myelogenous Physician Oyeung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to far as a consequence off: Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: use Use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day ģ in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 the i 9 Unknown 9 Unknown à signed t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 page certificate 2 No 1 ☐ Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home ٩ 1 ☐ Yes 2 No 3□ DOA 2 ER/Outpatient 5 Sesidence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending 4 hours after death. Funeral Director: Aft ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signatine and title of cer on who completed cause of death (Item 23a) (Type, Prim Name and address of per 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien205Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST 24 2005 **Physician** 3:00P M DOROTHY ELAINE SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 2007 E. LANVALE STREET BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 212 F Vrs 216-14-8855 04/24/1919 Director 86 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City Town or Location the Medical Examiner must be notified at XXYes 2 □ No Director MD N/ABALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2007 E. LANVALE STREET 21213 USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2X No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) JOHNS HOPKINS Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event. In 2008. HOSPITAL DENTAL TECHNICIAN 12TH YEARS 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) WILLIAM BOWE RENA JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 854 DERBY FARMS DR., SEVERN, MD 21144 BENJAMIN A. SMITH, JR /SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ery, crematory or other place)
ETERANS CEM
ISON FOREST 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/01/05 OWINGS MILLS 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on good line. Approximate Interval Between Onset and Death olen Immediate Cause (Final disease or condition Priysician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of): Examine signed by the attending physician and d be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 🙀 No 2 ER/Outpatient 3 DOA After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation

death certificate be executed P.O. Box 68760 Division of Vital Hospital or Attanding Physician: or 28a-f show

"natural", or Items 23a

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

Medical within 24 hor To the Fune State Registrar

this

after death. | Director: Aft

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WO GENE E GLEEN

2005

6 Could not be determined

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

31. Date filed (Month, Pay, Year) AUG 2 9

29b. Signature ar

1000 E. FAC STREET ₩egistrar's Signature

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D005693

By Jun E

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Datę signed (Month, Day, Year)

21202

25/05

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** Mildred Lorraine Sipes 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City Baltimore City** Catonsville Commons / Genesis Eldercare If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1□ M 2 KF Months Director 213.20.1986 MARYLAND June 2, 1926 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 27 is marked other than "natural", or Itams 23e or 28a-1 show traumatic event, the Medical Examinan must be realthed at 1 Yes 2 No Director Catonsville Marvland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 21228 U.S.A 176 Cherrydell Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at home al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker unknown re, Marylan.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Important: If item 27 is an eny injury or care. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First. Middle, Last) Be Virginia Robinson Conrad Deller 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 176 Cherrydell Road Catonsville, Maryland 21228 Ms. Patricia Ann Davis <u>Neice</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Re Date 20c. Location - City or Town, State loval from State 08/22/2005 Donation 5 Other (Specify, Sykesville, Maryland All County Cremation Services, Inc. 22. Name and Address of Facility Signature of Funeral Service Line Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21943 modeller M0053 ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Approximate Interval Between 23a art1. Enter the dis-In mediate Cause (Final Insease or condition resulting in death) **Physician** /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? ō 4☐Pregnant at time of death 5 Other (specify) P.O. I detached the 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an certificate has autopsy 1□ Yes 2☑No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 🗶 No 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: After Attending 1 Natural 2 Accident 5 Pending investigation 2 🗆 No 1 Tes death. within 24 hours after dealt To the Funerel Director: filled in by the 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide ò Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Type 5001 32. Registrar's Signature 31. Date filed (Month, Day, Year, State AUG 29 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N.2005 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11, 8:10 P. M THARP **AUGUST** 2005 MARGARET /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE 1 AURF1 CHERRY LANE NURSING HOME If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) DEC. 14, 1942 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F Yrs 62 MARYLAND 216-38-5268 14, Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a State ir than "natural", or Itema 23a or 28a-f show the Modical Examiner must be rutified at 1 Yes 2 No Director PRINCE GEROGE LAUREL 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20707 USA 410 TALBOTT AVENUE Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2X☐No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 EMERGENCY DISPATCHER P.G. POLICE DEPARTMENT other 7 la marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGUERITE WHITING JAME L. COON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1005 10TH STREET, LAUREL, MARYLAND 20707 item 27 l THERESA HARPER / DAUGHTER Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place) 0 = 0 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 8/15/2005 BRENTWOOD, MARYLAND FT LINCOLN CEMETERY \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLECK FUNERAL HOME 21. Signature of Funeral Service Licensee 7601 SANDY SPRING ROAD, LAUREL, MARYLAND WWW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE CEREBRAL THROMBOSIS MINUTES Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTATIC CARCINOMA MONTHS Sequentially list conditions Due to lor as a consequence of Examine cause. Enter Underlying Cause (Disease or injury certificate be executed inding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day for 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records. P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2**X** No 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 X Naturai 5 Pending 1 Tyes 2 No death. investigation othe Hospital or Attendi thin 24 hours after death. othe Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM A. WARREN, MD 321 PRINCE GEORGE STREET, LAUREL, MARYLAND 20707 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) AUGUST 15, 2005 **Physician** Year 4:50 P. YOGESH TIWARI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL **GAITHERSBURG** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT. 28, 1936 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1**X** M 2□ F 69 Yrs. 220-33-4197 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MONTGOMERY **GERMANTOWN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12512 EAGLE VIEW WAY 20876 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: INDIAN Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALES permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if item 27 is marked other ti eny injury or other traumatic event, III. 9mce. 12 FOOD SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GIRDHAR L. TIWARI SRIDEVI DWIVEDI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) USHA TIWARI / WIFE 12512 EAGLE VIEW WAY, GERMANTOWN, MARYLAND 20876 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 8/15/2005 BELTSVILLE, MARYLAND 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARRYTHMIA SECONDS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X3Unknown DIABETES peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **HYPERTENSION** s certificate has t lirector, page 2 s autopsy performed? 1 Yes 2 No CORNARY ARTERY DISEASE 3/X No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 🗵 No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation 1 Yes 2 No uneral Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 051929 AUGUST 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND AARON SNYDER, M.D. 31. Date filed (Month, Day, Year) AUG 2 9 2005 2. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NALDVOGEL 200 スラ /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHN HOPKINS BAYVIEW paltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 AF Year) 17-26-74 Yrs. **Director** Maryalnd Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits t than "natural", or items 23a or 28a-f ahov the Medical Examiner is ust be notified at Baltimore MD Rosedale 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 21237 8125 Old Philadelphia Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Medical 12th Telephone Operator permit. Pages 1 and 2 should be filled Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Agnes E. Whitbecker John Conniff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Waldvogel / son 21085 1327 Stockton Road Joppa, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 9/3/05 Rosedale, MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licensee 1211 Chesaco Ave. Rosedale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician onemonia /Medical Due to (or as a consequence of): Examiner unatoid arthritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner rsician and e burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed ant lacto Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical phy 38 IF FEMALE: nse s 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? Day Year 5 Other (specify) sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Luknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 N 25. Was case referred to medical 26. Place of Death Check on one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Living Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fr investigation М 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33316 Hapkin Bayvier Circle Baltimore MOZIZZY 30. Na and address of person who completed cause of death (Item 23a) (Type, Print) Bellentone 2005 32. Redistrar's Signature State Thereus. Registrar

Peggy Williams 05-5703 AKG

> Physic /Medi Exami

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

IID	Please T	ype or Print	t in Black I	ndelible	e Ink.	Ensu	re All	Copies	Are	Leg	ible.	
	1 - For State Registrar	State of Ma	ryland / De	partmer <i>ertificat</i>	nt of H te of L	ealth a D <i>eath</i>	nd Me		gien Reg. N		05	28151
an	1. Decedent's Name (First, Middle, Last)  Peggy A.	Williams						2. Date of De. Month August	D:	B, 20	05 <sup>Year</sup>	3. Time of Death 6:39 P M
er	4a. Fecility Name (If not institution, give s 5916 Darien Court	treet and number)			Town, or	Location of Ore	Death		40	c. County	of Death	
	210-30-0330	M 2 X F 7. Age	(In yrs. last birthda 73 Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	Date of Bird (Month, Da Jan. 9	v Year	32	Coun	lace (State or Foreign try) /land
ctor	Usuaf Residence of Decedent  10a. State 10b. County  Maryland N/A		10c. City, Town or Baltim						<del></del>		1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
Funeral Director	10e. Street and Number 5916 Darien Cour	rt		10f. Zip	Code 2	1206			-		what Coun ed Sta	•
by Funer	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	<ol> <li>Was Decedent Ev Armed Forces?</li> <li>1 ☐ Yes 2 X No If Yes, Give Year or Dates:</li> </ol>		3. Was Dece ff Yes, spe 1 ☐ Yes	cify Cuba	spanic Orig n, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No can, etc.)			ck, White,	
Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Gi	cedent's Usua ive kind of wo a. DO NOT u rderin	ork done d ise retired	luring most )	of working	7			usiness/Ind	
Be	12 yrs. 17. Father's Name (First, Middle, Last)			r der III	19 01	18. Mother		First, Middle,	Maide	n Sumar		ici y
P	Unknown  19a. Informant's Name/Refationship (Typ	ne, Print)	19b. Ma	iling Address	s (Street a	Ai (		Will Route Number			State, Zip	Code)
	Mrs. Jane E. Moral	es/Sister-	in-Law	3573 N	Mimi		. \	ork, <u>I</u>		1740		
	20a. Method of Disposition  1 □ Burial 2 A Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dis cemetery, c	rematory or c	other place	. 1	Dai 29.29				City or To	
	21. Signature of Funeral Service License	Michael E.		22. Name ar	nd Addres	-	1	Ę	305	Har	ford e, MD	Rd.
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line Arterios	he death. Do not e sclerotic consequence of):						rest,			Approximate Interval Between Onset and Death
Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of).									-
<u>e</u>	that initiated events resulting in death) Last	Due to (or as a	consequence of):									
Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12ymonths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1∐Live birth 2 4∐Pregnant at ti 9∐Unknown	☐ Fetal death 3	3 ⊟Ectopic pr 5 ⊟ Other (sp							te of delive onth	ry Day Year
d by Pl	Part II. Other significant conditions conf	tributing to death but	not resulting in the	underlying o	ause give	n in Part I.		l			tribute to th	e cause of death? ably 4 X Unknown
Complete							_	24a. Was autop perfor 1 Yes			Were autor prior to con death? 1  Yes	osy findings available inpletion of cause of 2 No
Be	25. Was case referred to medical examiner?	ospital:			Othe			Check only o				
ion; To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b. Time	of 2	28c. Injury Work	at ?	28	d. Describe h				at scene
ertificat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury building, etc.		street, factory		∕es 2 □ N		f. Location (S City or Tox			per or Rura	Route Number,
Medical Certification;	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	icien: To the best of er: On the basis of e and manner state	examination and/or	ath occurred investigation	at the tim	e, date and inion, death	place, and occurred	d due to the o	ause(s	s) and ma d place,	anner as sta and due to	ated. the cause(s)
Me	29b. Signature and title of certifier				c. License					-	d (Month, L	**
	+ Hamule Freehou	U, MD			O.C.M	l.E.		I	Augu	ıst 2	24, 20	JU5

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pamela E. Southall, m. 111 Penn Street, Baltimore, Maryland

31. Date filed (Month, Day, Year)

AUG 2 9 2005

21201

	an cal	Baby boy	(Henapo	KEVIN	ALE	KANDER WILL	LAMS 2	2. Date of Death Month	Day Year	5 0556 A M
xamir	er	4a. Facility Name (If not institution	n, give street and nur	mber)		4b. City, Town, or Loca	ation of Death	u	4c. County of De	ath
neral ector		5. Social Security Number	6. Sex 1 M M 2 □ F	7. Age (In yrs. last N/A	birthday) Yrs.		Jnder 24 Hrs. purs Min.	B. Date of Birth (Month, Day, 1	Year) 9. Bi	irthplace (State or Foreign Country)
		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	our or l	· · · · · · · · · · · · · · · · · · ·		0 - 0		
N C N	lor		altimore	Too. Oily, 10	OWIT OF EC		ındalk			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
TION I	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	Country?
al la		1918 Frames	Road			21	L222	τ	United St	ates
Examiner institution	by Funeral	11. Marital Status  1   Never Married 2   Mar  3   Widowed 4   Divorced	ried 1 ☐ Yes	2 Mo 'e No		Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 🏻 No Spe	sic Origin? (Speci exican, Puerto Ri ecity:	fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:	ite, etc.
Palical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed)		(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	10	3b. Kind of Busines:	White s/Industry
ent, the M		N/A 17. Father's Name (First, Middle,	l ast)		Ι	ependant	Mother's Name (	First Middle M	N/A	
matic eve	o Be	matthew Pa	WICK WI	lliams			_			rapace
2 2	-	19a. Informant's Name/Relations		Kary 1	9b. Maili	ng Address (Street and N	lumber or Rural I	Route Number, (	City or Town, State,	Zip Code)
other tr		Lillian Willi		nother)	1918	Frames Road	Dunda		yland 212	
		20a. Method of Disposition 1 □ □ □ Cremation		State ceme	itery, crei	natory`or other place)			oc. Location - City o	
3 3		* 4 □ Donation 5 □ Other (S 21. Signature Funeral Service	1	Oak I		Cemetery  2. Name and Address of F	8/26/20 Facility	05	Baltimor	e, Maryland
any		1 Japan E	-Keed			uda-Ruck Fu 1922 Wise Av				Inc. 21222
		23a. Part1. Enter the disease of shock, or hear failure. List	r complications that conly one cause on e	aused the death. D						Approximate Interval Between
ician		Immediate Cause (Final disease ir condition	- Sev	leve pr	em	aturity				Onset and Death
ical iner		resulting in death)	Due to (	or as a consequence	,	xioamn	نسا ۔ ا			10 min.
	iner	Sequentially list conditions,	b. Qua to (	The second secon	VI IC	VIOUITI	100111	·		10/11/
USII	트미	ir airy, isading to immigate		or as a consequent			1107			
G.	аш	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S c	or as a consequenc			7.07.11			
ourial-tra	i Exam	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence	te oi):					
s the burial-tra	dicai	that initiated events	cDue to (		te oi):					
for use a:	dicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	or as a consequence of pregnancy inth 2 Fetal deal	ce of):	Ectopic pregnancy			23d. Date of de Month	Day Year
lached for use a	hysician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	or as a consequence come of pregnancy irth 2 Fetal dea ant at time of death	e or):  ath 3 5	Ectopic pregnancy			Month 8	Day Year 21 OS
be detached for use a	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	or as a consequence come of pregnancy irth 2 Fetal dea ant at time of death	e of):	Ectopic pregnancy			Month S cco use contribute t	Day Year
page 2 should be	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	or as a consequence come of pregnancy irth 2 Fetal dea ant at time of death	e of):	Ectopic pregnancy		23e. Did toba  1  Yes  24a. Was an autopsy performe	Month  Coco use contribute t  No 3 P  24b. Were a prior to	Day Year 2   S  o the cause of death?  robably 4   Unknown  utopsy findings available completion of cause of
certificate has been signed by the attending rector, page 2 should be detached for use a	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown NA  Part II. Other significant conditions are conditionally as the conditions of the conditi	23c. If yes, out 1 □ Live b 4 □ Pregn 9 □ Unknot  Ons contributing to de	come of pregnancy irth 2 Fetal dea ant at time of death own	ce of):  ath 3 5	DEctopic pregnancy Other (specify)  nderlying cause given in F	Part I.	23e. Did toba  1  Yes  24a. Was an autopsy performe 1 Yes  Check only one)	Month CCCO use contribute t  No 3 P  24b. Were a prior to death? 1 Yes	Day Year 2   ST  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
director, page 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No	d	come of pregnancy inth 2 Fetal dea ant at time of death own	ce of):  ath 3 5	DEctopic pregnancy Other (specify)  Inderlying cause given in Figure 26. Figure 3 DOA  Other: 4	Part I.  Place of Death (i  □ Nursing Home	23e. Did toba  1  Yes  24a. Was an autopsy performe 1 Yes  Check only one)	Month Coco use contribute to the contribute to t	Day Year 2   ST  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
director, page 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No	d	come of pregnancy inth 2 Fetal dea ant at time of death own eath but not resulting inpatient 2 Fe/of Injury 28t	ce of):  ath 3 [ 5 [  Outpatier  Time of Injury	Dectopic pregnancy Other (specify)  Inderlying cause given in R  26. I  Other: 4  Injury at Work? Injury at Work?	Place of Death (i	23e. Did toba  1 Yes  24a. Was an autopsy performe 1 Yes  25Check only one) 5 Residend d. Describe how	Month  Coco use contribute to the coco use coco use contribute to the coco use contribute to the coco use contribute to the coco	Day Year 2   ST  o the cause of death?  robably 4   Unknown  utopsy findings available completion of cause of s  No
in make in botton. Area line command has been signed by the attention of the funeral director, page 2 should be detached for use an	Certification; To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions are awaminer?  1  Yes 2 No  27. Manner of eath 1  Natural 5 Pendir investif 2 Accident 3 Suicide 6 Could determ  29a. Certifier Certifyin	d.  23c. If yes, out 1	come of pregnancy inth 2 Fetal dea ant at time of death own seath but not resulting the patient 2 Fetal dea and at time of death own seath but not resulting the patient 2 Fetal death own seath but not resulting the patient 2 Fetal death own seath but not resulting the patient 2 Fetal death of the patient	ce of):  ath 3 5 0  g in the un  Outpatier  Time of Injury  farm, str	Dectopic pregnancy Other (specify)  Inderlying cause given in R  26. I  Other: 4  Injury at Work? Injury at Work?	Place of Death (in Nursing Home 28)	23e. Did toba  1 Yes  24a. Was an autopsy performe 1 Yes 25  Check only one)  5 Resident 1. Describe how city or Town, side due to the cau-	Month  Coco use contribute to the contribute to	Day Year 2   ST  o the cause of death?  robably 4   Unknown  utopsy findings available completion of cause of secify)  fural Route Number,
ineral director, page 2 should be detached for use a:	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   No 12   No 14   No 14   No 15   No 1	23c. If yes, out 1   Live b 4   Pregn 9   Unknown ons contributing to de  I Hospital: 1 28a. Ite of (Montage) 1 28e. Place building 1 Physician: To the Examiner: On the be and man	come of pregnancy inth 2 Fetal dea ant at time of death own seath but not resulting the patient 2 Fetal dea and at time of death own seath but not resulting the patient 2 Fetal death own seath but not resulting the patient 2 Fetal death own seath but not resulting the patient 2 Fetal death of the patient	ce of):  ath 3 5 0  g in the un  Outpatier  Time of Injury  farm, str	Dectopic pregnancy Other (specify)  anderlying cause given in Figure 26. If the 3DOA  26. Injury at Work? M 1 Yes eet, firstory, office	Place of Death (complete Notes and place, and, death occurred	23e. Did toba  1  Yes  24a. Was an autopsy performe 1  Yes  25  Check only one)  5  Resident d. Describe how  City or Town, 3  d due to the cau at the time, date	Month  Coco use contribute to the contribute to	Day Year 2   ST  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of s  actify)  fural Route Number,  s stated, e to the cause(s)
ely filled in by the funeral director, page 2 should be delached for use a	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes 2   No	23c. If yes, out 1   Live b 4   Pregn 9   Unknown ons contributing to de  I Hospital: 1 28a. Ite of (Montage) 1 28e. Place building 1 Physician: To the Examiner: On the be and man	come of pregnancy inth 2 Fetal dea ant at time of death own seath but not resulting the patient 2 Fetal dea and at time of death own seath but not resulting the patient 2 Fetal death own seath but not resulting the patient 2 Fetal death own seath but not resulting the patient 2 Fetal death of the patient	ce of):  ath 3 5 0  g in the un  Outpatier  Time of Injury  farm, str	26. Injury at Work?  In occurred at the time, dar vestigation, in my opinion.	Place of Death (complete Notes and place, and, death occurred	23e. Did toba  1  Yes  24a. Was an autopsy performe 1  Yes  25  Check only one)  5  Resident d. Describe how  City or Town, 3  d due to the cau at the time, date	Month  Coco use contribute to the coordinate of	Day Year 2   ST  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of s  actify)  fural Route Number,  s stated, e to the cause(s)

State of Maryland / Department of Health and Mental Hygien 2005 28153 1 - For Stata Ragistrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 Year AUG **Physician** JOHN AVANT JR. L. 8 10:08PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FT. WASHINGTON HOSPITAL FT. WASHINGTON P.G. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (St. Month, Day Year) 959 WASH. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1₩ M 2□F 45 579 92 0392 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other then "natural", or items 23s or 28s-f show other treumstic event. The Medical Engineral retailed to MD. P.G. FT. WASHINGTON 1XYes 2 No Director 10e. Street and Number 9403 TESTER 10f. Zip Code 10g. Citizen of What Country? 20744 DRIVE USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene importent: if Item 27 is marked other then "natural", or item any injury or other treumatic event, the Medical Eventment Black, White, etc. Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry lite DO NOT use retired)
BEAUTICIAN Elementary/Secondary (0-12) College (1-4or 5+) PVT. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOHN L. AVANT SR. DELORES EDWARDS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9403 TESTER DR. FT. WASH., MD. 20744 JOHN L. AVANT SR./FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARKLAWN CEM. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ROCKVILLE, MD. 8/16/05 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WATSON 21. Signature of Funeral Service Licensee F H 20010 3435 14th ST., N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Kes pirator disease or condition resulting in death) /Medical Examiner Sequentially list conditions, aux. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit The law requires that the death certificate be executed Acquired Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) \_ ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3. Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6196 OXON HILL RD. OXON HILL MD. 20745 ASHBIR WOLDEABEZGI MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28154 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2005 August 11, 9:32 Wanda Violet Awad /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 31,1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2**X** F 86 212-54-7014 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State in then "neturel", or items 23e or 28e-f show the Medical Examinar nust be initial at 1 Tyes 2 No Maryland Montgomery Silver Spring Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 10202 Gardiner Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Я 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Importent: If Item 27 is marked otheny injury or other treumetic event Ursula Mecavage Charles Klementovich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9504 Barroll Lane, Kensington, Maryland 20895 John Michael Awad/ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 15 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2005 Silver Spring, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) d 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc once. 500 University Blvd, W, Silver Spring, Md 20901 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebral Bleed /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 XNo Division of Vital the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death of or Attending Patter death. After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funerel D completely filled i Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print)
M.D. P.O. Box 83819, 30. Name and address of person 3 Gaithersburg, MD 20883 Neeraj Chopra, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

Concentration   Concentration   Control   Co				State of Maryland / Dep State Registrar  State of Maryland / Dep	artment of Health and N rtificate of Death		ne No. 2005	28155
Eminant  Feminant  Feminant  Chesspeake Woods Center  Chesspeake Woods						2. Date of Death		3. Time of Death
Formal Principles  Financial  Fin				Earl Dunnock Asplen				6:50 p <sup>M</sup>
South Security Number   2 Sear   2 Se				4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Deal	th
27 G-09-9972 If We still in the first of the								
The second process of				15/14 2005		(Month, Day, Ye	9. Bird	thplace (State or Foreign
100   State   100   County   100				210-09-0972		NOV. 16,	1903	aryland
William Johns Asplen   Simulation (Course)   Simulation of Plant and Surviva or Town, State, 25 Code)   Simulation (Plant and Surviva)   Simulation (Plant and Surv	~	yland now			ocation			10d. Inside City Limits
William Johns Asplen   Simulation (Course)   Simulation of Plant and Surviva or Town, State, 25 Code)   Simulation (Plant and Surviva)   Simulation (Plant and Surv	$\langle$	a-fsh	to	MD Dorchester	Woolford			1 ☐ Yes 2 🗹 No
William Johns Asplen   Simulation (Course)   Simulation of Plant and Surviva or Town, State, 25 Code)   Simulation (Plant and Surviva)   Simulation (Plant and Surv		or 28	ire		,	10g.	. Citizen of What Co	ountry?
William Johns Asplen   Simulation (Course)   Simulation of Plant and Surviva or Town, State, 25 Code)   Simulation (Plant and Surviva)   Simulation (Plant and Surv	)	ath w						
William Johns Asplen   Simulation (Course)   Simulation of Plant and Surviva or Town, State, 25 Code)   Simulation (Plant and Surviva)   Simulation (Plant and Surv		er dea	nne		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		
William Johns Asplen   Simulation (Course)   Simulation of Plant and Surviva or Town, State, 25 Code)   Simulation (Plant and Surviva)   Simulation (Plant and Surv	5	rs aft	by F	If Vos Give	1 ☐ Yes 2 ☑ No Specify:		Specify: V	white
William Johns Asplen   Simulation (Course)   Simulation of Plant and Surviva or Town, State, 25 Code)   Simulation (Plant and Surviva)   Simulation (Plant and Surv		2 hou atura	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	161	b. Kind of Business	Industry
William Johns Asplen   Simulation (Course)   Simulation of Plant and Surviva or Town, State, 25 Code)   Simulation (Plant and Surviva)   Simulation (Plant and Surv	-	thin 7 e. an "n	ple	life.	DO NOT use retired)	Kiirig		_
William Johns Asplen   Simulation (Course)   Simulation of Plant and Surviva or Town, State, 25 Code)   Simulation (Plant and Surviva)   Simulation (Plant and Surv	1	ed wii	Con	7				rd
Security   Company   Com	2		Be				_	
Security   Company   Com	Ž	hould d Mer narks natic	2					Zin Code)
Secretary   Community or other place)   Table   Tabl	2	d 2 si th an th an traur		, , , , ,	•			
Physician (Medical Examines)  Physic	טֿ	tam S		20a. Method of Disposition 20b. Place of Disp	osition (Name of			
Physician (Medical Examines)  Physic	2	ages ent of t: If i		1 M Burial 2   Cremation 3   Hemoval from State		13/05 C	hurch Cre	ek, MD
Physician (Medical Examines)  Physic		mit. I partm sortai / inju			_			•
Shock of hear failure. List only one cause or gach line.    Physician (Modical Examiner)   Ph	Š	E G E E G		Bik. Bi	700 Locust St., Ca	ambridge,	MD 21613	3
Physician Medical Examinor    Physician Medical Examinor   Physician Continue   Physician Con				23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest		Interval Between
Sequentially list conditions, a consequence of):    Sequentially list conditions, auditions, auditi		Physician		disease or condition	ruthmia			Minutes
Due to (or as a consequence of):    Due to (or as a consequence of):				Due to (or as a consequence of):	J			
Due to (or as a consequence of):    Due to (or as a consequence of):		Laminor	-	Sequentially list conditions,  Due to (or as a consequence of):		<u> </u>		years
Due to (or as a consequence of):    Due to (or as a consequence of):		tad nsit	nine	cause. Chief Underlying Cause (Disease or injury				•
The part of the pa		axecu n and al-tra	xar	that initiated events c.				
FFEMALE   23b Was decedent pregnant   1   1   1   1   1   1   1   1   1	5	e be	call	d				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	0	tificat ng phy as th	0	TERMINE.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	2	ith car tandir r use	an/h	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	⊒Ectopic pregnancy			•
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	, ,	e dea the at	slci	1 Yes 2 No	Other (specify)		IVIOTATI	Day rou
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	Ĺ	hat th id by detacl			underlying cause givernin Part I.	23e. Did tobac	co use contribute to	the cause of death?
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	Ď,	signs d be	d by	Hupothuroidism Colon C	ancer Diabe	es 1□Yes	2 No 3 Pr	obably 4 Unknown
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	5	w request	lete			24a. Was an	24b. Were au	utopsy findings available
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	ב ב	he lar e has age 2	duc			autopsy performe	prior to death?	completion of cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	g	an: T tificat tor, pa	ø	25. Was case referred to medical	26. Place of Dea		1/40 1 1 1 485	2   140
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	5	ysici iis cer direc	.0	Hospital:	nt 3 DOA Other: 4 Nursing H	ome 5 Residenc	e 6 Other (Spe	cify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	<b>S</b>	ng Ph fter th neral			of 28c. Injury at Work?	28d. Describe how	injury occurred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	2	eath. or: A the tu	catle	2 Accident investigation				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	<u> </u>	or Att	ırtifi	determined 289. Place of Injury - At nome, farm, s	treet, factory, office			ural Houte Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature	_	pital ours a aral (		29a Certifier Certifying Physician: To the best of my knowledge dea	th occurred at the time, date and place	and due to the caus	ea/s) and manner as	stated
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature		a Hos 24 hc a Fun etely	dica	(Crieck only 2   Medical Examiner: On the basis of examination and/or in	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (100 Bramble Street Cambridge, MD 21613  State  31. Date filed (Month, Day (Part) 1 5 2005)  32. Registrar's Signature		To thin Mithin To thi	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)
State 31. Date filed (Month, Day Kear) 1 5 2005 2. Registrar's Signature				pa a / pm 1.0.	140044613	5	8/2/0	S
State 31. Date filed (Month, Day Kear) 1 5 2005 2. Registrar's Signature				30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Oa L	- nax	110/	12
State Registrar 31. Date filed (Month, Day 1647) 1 5 2005 2. Hegistrar's Signature				190 Dramble Street	Lumbridge	e, IVID	216	,, ')
				31. Date filed (Month, Day) 62 1 5 2005 2. Registrar's Signature	Josh	•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200528156 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** Ytch August be. 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner a Polis | Min. | B. Date of Birth (Month, Day, Year) Anne Center Arunde Arunde nne Medica 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Birthplece (Stete or Foreign Country) **Funeral** Days 102M 2□F Months 38-8440 4 Yrs. Director G- DA- v 1941 Maryland JUNE Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itama 23a Roac 61 Funeral Newtown 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 20 No Specify þ Specify: 3 ☐ Widowed 4 ☑ Divorced "natural", Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Seafood Industr DRIVER 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Bernice ပ Arthur Jones, LPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Car Aytch Rd. Grasonville 116 Forest Maryland hirlel 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Important: If it eny injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/16/05 Chester, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address I Facility Henry Funeral Home, P.A. 21. Signature of Funeral Service Licenses Janelle 510 Washington St. Cambridge, MD12/61 23a. Part1 Inter the disease, or complications that caused the shath, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such a cardiac or respiratory arrest, Immediate Cause (Final Physician 6 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and the detached for use as the burial-transit or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as been si 2 should b 2 🗌 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has rector, page 2 autopsy performed 2 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Medical Certification; To 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1—Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To tha Funeral Director: completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Fo the 29b. Signature and title of califier 29c. License number 29d. Date signed (Month, Day, Year) 32036

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records,

D. Done

Thrive chost. MO 216/9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1 2 2005

are

2101

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 2005 2:50PM M 14 FRED T. BEAR 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT WILLIAM HILL MANOR EASTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAX 6 1 930 Birthplace (State or Foreign PA Sex 14 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 75 138-24-5983 Usual Residence of Decedent Od. Inside City Limits 10a. State 10b. County 10c. City, Town or Location YYes 2 □ No EASTON MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA 501 DUTCHMANS LANE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FAMILY MEDICINE DOCTOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CATHERINE NICHOLAS SIMON BEAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9826 MARTINGHAM CIRCLE, ST. MICHAELS, MD 21663 JUNE O. BEAR/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 24 Cremation 3 Removal from State CHESAPEAKE CREMATION CTR 8/15/2005 STEVENSVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERDE JOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause weach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Parkinsons 54R8 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. East underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 XIIIo 1 🗆 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Mapper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) D35284 who completed cause of death (Item 23a) (Type, Print)
Hun no 2195. Washington St Easton mo 21601 Allon mp AUG 1 7 2005 egistrar e signature

DHMH 17 Rev 1/2001

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r then "natural", or items 23e or 28e-f show the Medical Examinational be notified at

1 and 2 should be filed within 72 hours after death Health and Mental Hygiene.

Pages ౼

altimore, Maryland 21215-0036

Director

à

Completed

Be

ဥ

Examine

Physician/Medical

Completed

Be

ို

Certification;

Medical

State Registrar

other

ŏ permit. Page Department of Importent: If any injury or once.

**Physician** 

/Medical

and I-transit

the attending physician a hed for use as the burial-

signed t

been signated

page 2

funeral director,

After

within 24 hours affer common To the Funerel Director: /

or Attending

To the Hospitel

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Examiner

State of Maryland / Department of Health and Mental Hygien 2005 28158 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 13,2005 **Physician** Ruby Pauline Brown 1:10 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Living Walucle
7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month. Day, Year) | North Fenwick Landing Assisted Living 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 219-48-5116 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "nature!" ---- any injury or other treumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 X No Maryland Charles LaPLata Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 U.S.A. 4010 Ray Drive Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by If Yes, and Year or Dates: White 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles D. Kline Lucy Sandy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13319 Fairfield Square Dr., Chesterfield, Missouri Donald H. Brown, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Trinity Memorial Gardens 16,2005 To Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 22. Name and Address of Facility
Williams Funeral Home, 21. Signature of Funeral Service Licensee P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HLZHEIMER De to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) the by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: injury at Work? After 1 Natural 2 Accident 1 Tyes investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the within 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per 20602 AUGMAN 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 2005 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2005 August 8:30 A Hazel Mae Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hearts of Hope Prince George's Lanham 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 ☐ M 2 🖺 F Months Yrs. Director 8, 1936 149-32-4203 North Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Show ?7 is marked other then "neturel", or items 23e or 28a-f shov traumatic event, the Madical Eventified at 1 XYes 2 □ No Director Maryland Prince George's Seabrook 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9751 Good Luck Rd., 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc a filed within 72 hours after all Hygiene.

I Hygiene.

other then "neturel", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Estee Lauder Tech. Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fitted in the Pages 1 and Mental H tent: If item 27 Is marked others. Willie Brown Annie Monroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9751 Good Luck Rd., #8 Eleanor Thornton - Sister Seabrook, MD 20b. Place of Disposition (Name of cemetery, crematory or her placem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Importent: If any injury or once. Nashville Miss. Bapt, 8/14/2005 4 ☐ Donation 5 ☐ Other (Specify) Marston, NC 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home ellou 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last and the death certificate be execu Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physician for use as the buria Physician/Medical as the IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the e ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Se Yes 2 □ No 1 ☐ Yes 2 DeNo or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other @up<sub>fy</sub>)Home 2 1 Yes 2 No this 28c. Injury at Work? 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide Hospitel within 24 hours To the Funerel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00052430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6201 Greenbelt Road, #L5 Greenbelt, MD Rosaline Fraser, M.D. 2. Registrar's Signature. 31. Date filed (Month, Day, Year) State AUG 1 5 2005 Registrar

			1 - For State Registrar	State of Maryland	d / Depa <i>Ce</i>	artment of H rtificate of L	ealth and M Death	ental Hygi Re	en2005	28160
			1. Decedent's Name (First, Middle, L.	ast)				2. Date of Death Month		3. Time of Death
	Physici /Medio		Darlene '	Vivian Bush				August	8 2005	
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			1914 Rochelle	Ave., #1416		Distr	ict Height	ts	Prince	George's
	Funeral			Sex 7. Age (In yrs. II 1 M 2 XF		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		579-70-3528	51	Yrs.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Jan. 18,	1954 W	ash., DC
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	neation				10d. Inside City Limits
	haryla sho	ō		George's		istrict He	eichts			1X Yes 2 □ No
	28a-1	ect	10e. Street and Number	ocorge b		10f. Zip Code		10	On Citizen of What C	
	with sor	ă		. "1116		TOT. ZIP COGO	007/7	10	g. Citizen of What C	
	eath	by Funeral Director	1914 Rochelle	Ave., #1416 12. Was Decedent Ever in U.S	3 19	Was Decedent of Hi	20747	city Voe or No-	14. Race - Am	States
	ter d	Ë	1 ☐ Never Married 21☑ Married	Amed Forces? 1 ☐ Yes 2 🏋 No	3.	If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	Rican, etc.)	Black, Wh	ite, etc.
336	urs at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give XY Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify:	trican merican
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show direal Examinar must be rodified at	Completed	15. Decedent's 8	Education	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Business	
218	hin 7 an "n Medi	pie	(Specify only highest gi	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of workir )	ng		
21	d wit giene er th	М	12th			Hous	sewife		Pri	vate
	al Hy oth	Be (	17. Father's Name (First, Middle, Las	t)			18. Mother's Name	(First, Middle, M	laiden Sumame)	
Maryland	Ment Ment Ment Ment Ment Ment Ment Ment	10	Walter H.	Hawkins, Sr.		and the second s		Vivian.	Rumme1s	
lan	2 sho and I		19a. Informant's Name/Relationship		1					Zip Code) 20747
	and and n 27		Raymond T. Bus				lle Ave.,	#1416,	District	Hgts, MD
ore	of He fiter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [	0.00	ace of Dispo metery, crea	sition (Name of matory or other place		ate 2	toc. Location - City o	r Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinational Perceitified at ODGe.		'4 □ Conation 5 □ Other (Spec		yland	Veterans	Cem. 8/2	3/2005	Cheltenha	m, MD
alt	permil. Departi Importi any inj once.		21. Signature of Funeral Service Lice	ensee	, 22	2. Name and Addres	s of Facility S1	tewart F	uneral Ho	me
Ш.	20 E 2 9		Volum 1.	Dlewood 111		4001 Beni	ning Rd.,	N.E. Wa	sh., DC 2	0019
П			23a. Part1. Enter the disease, or con shock, on heart failure. List only	inplications that caused the death one cause on each line.	. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a Stroke						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	ence of):		· · · · · · · · · · · · · · · · · · ·			
	Examiner		Sequentially list conditions	b. Brain Me	tasta	sis				
	ים מ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					
	ecute ind trans	E	Cause (Disease or injury that initiated events resulting in death) Last			ng Cancer				
30,	sian surial	û	rosuning in death) cast	Due to (or as a consequ	ence of):					
68760,	icate be executed physician and s the burial-transit	edicai	•	d						
_	entific ding p		IF FEMALE:	00-14						
Вох	eath certifi attending   I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
	the a	Physician/M	1 ☐ Yes 2 🎇 No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5∟	Other (specify)				- 4,
P.0	The law requires that the death certificate be executed ate has been signed by the attending physician and orge 2 should be detached for use as the burial-transit		Part II. Other significant conditions	contributing to death but not resu	Iting in the u	ndorhina causo awa	on in Part I	23e Did toba	acco use contribute t	o the cause of death?
S,	ires t signe d be d	by	Tarris official sections	outilibrating to doutil but not resu	iling in the u	nderlying cause give	ni ii i arti.	77		robably 4 Unknown
0	w requir been si should	etec								
Sec.	e law has t	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
of Vital Records,	ilcian: The certificate rector, pag	S		,				1 Yes 2	ed? death? ZNo 1 □ Yes	s 2□No
Vita	Ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		0.5	26. Place of Death			
of	Physician: this certificatal director, a	2	1 Yes 2 XNo  27. Manner of Death	1 □ Inpatient 2 □ E	R/Outpatier		4   Nursing Hon		nce 6 Other (Spe	ecify)
n	ding Physician: The h. After this certificate ha funeral director, page	Certification:	1 XNatural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	Work		8d. Describe hov	v injury occurred	
<u>S</u>		icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not it	De Con Blancot Inium Atta			′es 2 □No	Of Landing (Cha		
Division	l or A after Direction by	artif	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, rarm, str )	eet, ractory, onice	2	City or Town,	eet and Number or R State)	urai Houte Number,
_	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune		29a. Certifier 1 Certifying P	hysician: To the best of my know	uladaa daati	and the time	a data and place a	ad due to the en-		
		edical	(Check only 2 Medical Exa	hysicien: To the best of my know miner: On the basis of examinati and manner stated.	on and/or in	vestigation, in my op	e, date and place, a inion, death occurre	d at the time, dat	use(s) and manner a te and place, and du	e to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	and marrier stated.	_	29c. License	number	29	d. Date signed (Mon	th, Day, Year)
	F 3 F 8		1111/00	11121/11 N	M	D(	0056791			
0	(A)		30. Name and address of person who	completed course of Aut (1)	222) (75:		JUJU/ 71		August	11, 2005
K	(5)						Lane. Uni	oer Marl	boro. MD	20774-5374
	Sta	ta	31. Date filed (Month, Day, Year)	39. Registrar's Signatu	ure		, op		, in	
	Registr	, 9 mg	AUG 1 5 200		do	B				
DH	MH 17 Rev 1/2		MOG I 3 ZOE	- Juliano A	- Jan					

		•	For State Registrar		State o	of Maryla				lealth and N Death		Reg. No.		5	281	-
	Physicia		1. Decedent's Name William		•						2. Date of De Month August		2005 Yea	•	3. Time of Deatl	
	/Medic Examin		4a. Facility Name (If 2205 Ou:	not institution, giv		ımber)		1		Spring			County of De		У	
	Funeral Director		5. Social Security Nu 057-22-8	ımber 6. S		7. Age (In yr.	s. last birthday Yrs.		er 1 Year	If Under 24 Hrs. Hours Min.	8. Oate of Bir July 2.				ce (State or Fore	sign
2	land ow		Usual Residence of 10a. State	Decedent 10b. County		10c. (	City, Town or L	ocation						100	I. Inside City Lim	nits
	Mary a-f sh	tor	Maryland	Montgom	ery	Si	lver Sp	ring							1 X Yes 2 □	No
	or 28:	Direc	10e. Street and Num		4				ip Code			_	izen of What			
	sath w	Funeral Directo		inton Ro		cedent Ever in	II.S. 13.		20910		pecify Yes or No		ited S			
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at price.	by Fun	11. Marital Status  1 □ Never Marrie  3 □ Widowed		Armed F 1 Tes If Yes, G Year or I	orces? 2 ⊒XNo ive		If Yes, sp		dispanic Origin? (Si an, Mexican, Puerto Specify:	o Rican, etc.)		Black, W	hite, et	C.	
2-003	72 hou	eted	(Speci	15. Decedent's E	ducation ade completed	)	16a. Dece	dent's Us	ual Occup	during most of word	king	16b. Ki	ind of Busine	ss/Indu	stry	
7 7	within ane. than "	Completed	Elementary/Secon			(1-4or 5+)	1	sici.		d)		Eı	nterta	inm	ent	
ם צ	e filed Il Hygie other	0	17. Father's Name (	First, Middle, Last	Unk.					18. Mother's Nam	ne (First, Middle	Maiden	Sumame)			
yland	ould be Menta arked atlc ev	ToB								Mariah						
Mar	12 sh thand 7 is m traum		19a. Informant's Na Jennifer			ghter		-		and Number or Ru reet, Si				o, <i>Zip c</i> 209		
<u>ē</u>	s 1 and f Heali fem 2 fem 2		20a. Method of Disp	osition		20b	. Place of Disp	osition (N	ame of		Date		ocation - City			
Ē	Page:			☐ Cremation 3 ☐ 5 ☐ Other (Speci		State P	arklawn	Mem	orial	Park 8					aryland	
Baltimore,	permit. Departimport. any inj		21. Signature of Fur	heral Service Lice	hence	son	2			ess of Facility Mc						12
P				rt failure. List only	plications that one cause on	caused the de each line.	ath. Do not er	iter the m	ode of dyir	ng, such as cardiac	or respiratory a	rrest,		1	Approximate nterval Between Onset and Death	
).	Physician /Medical		Immediate Cause ( disease or condition resulting in death)	Finat n	_ d			Car	divas	scular Di	sease				-	
	Examiner			- 1	Due to	o (or as a cons	equence or).									
\$ <sub>2</sub> -	P ==	Iner	Sequentially list cor if any, leading to in- cause. Enter Under Cause (Disease or that indiated events	nditions,	Due to	(or as a corie	equanea of):							11		
	xecute and II-trans	Examiner	that initiated events resulting in death) L	ast	c. Due to	o (or as a cons	equence of):							+		
8/60	ficate be executed physicien and s the burial-transit	edical E		•	_ d									1		-
D	entifica ting ph		IF FEMALE:		33a If yes o	utcome of orac	3020CV						004 0-14	d = 15		
O. Box	at the death certifi by the attending prached for use as	Physician/M	23b. Was decedent in the past 12 1 Tes 2 Dunknown	months?	1□Live	utcome of preg birth 2 □ Fe gnant at time o nown	etal death 3	□Ectopic □ Other (		у			23d. Date of a Month		yay Year	
2	ires tha signed d be de	þ	Part II. Other signifi	icant conditions	contributing to	death but not r	esulting in the	underlying	cause giv	ven in Part I.		obacco u	•••		cause of death	
Records,	sw requ	Completed									24a. Was		24b. Were	autops	sy findings available to or cause	able of
He	The ate h page	Com									perfo	ormed? 2 🗓 No	death		_	01
of Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referrexaminer?		Hospital:				Ott	26. Place of Dea						
on of	Phys this al dii	lon: To	1 ☐ Yes 2 ☐ 27. Manner of Death 1 ☐ Natural	h 5 🗆 Pending	28a. Date (Mo	Inpatient 2 e of Injury onth, Day Year	28b. Time		28c. Inju Wo	4 14013IIIg F	ome 5X Resi 28d. Oescribe			pecify)		
Division	al or Attendii safter death. I Director: A id in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6  Could not determined	28e. Plac	ce of Injury - Al ding, etc. (Spe	t home, farm, s				28f. Location ( City or To			Rural	Route Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical Co	29a. Certifier (Check only one)		miner: On the					ime, date and place opinion, death occu						
	To the within To the comple	Me	29b. Signature and	title of certifier	20	,		2	9c. Licen:	se number		29d. Da	te signed (Mo	onth, D	ay, Year)	
)				100	rest	w	1		2	16245		M	× 11	14	2005	
	10		30. Name and addr	ess of person who atel, M.					e. 12	Censingto:	n MD (	20895	5			
į.	Sta	ate	31. Date filed (Mon	th, Day, Year)		Registrar's Sig	gnature			спативсо	ii jii 2	.007.				
	Regist		A	UG 152	(005   🔏		H. B	racks	1							

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 1400 M 2005 Vildred /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** Salisbury
If Under 1 Year If Under 24 Hrs. Wicomico Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Months Hours 1 M 215KF Director 214-32-0079 74 May 28, 1931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified of Director MD Wicomico 1 Yes 2 No Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21688 Deep Branch Road 21856 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🕱 No þ Specify: white 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. h and Mental Hygiene. 7 is marked other than "n. College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ulysess William Carey Olivia Virginia Pennwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun Doris Brewster 21688 Deep Branch Road, Quantico, MD daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Dorchester Memorial Park 8/15/05 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VAN CED **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DASA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 99 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 XNo 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Hospital: 1 | Inpatient Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$  Other (Specify)  $\square$  PICR 1 ☐ Yes 2 No P 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending hours after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 D58410 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARROWWOOD HULAW WARIS 26266 CT. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			For State Registrar	State of M	aryland / De	epartment of li Certificate of	Health and Death	Mental Hy	giene 20	05	281	64
			Decedent's Name (First, Middentification)					2. Date of Dea	ath		3. Time of	Death
	Physici /Medio		ROBERT	U.		LEMAN		Aug 17	, 200	5 ' 1	13:40	рм
	Examin		4a. Fecility Name (If not institution Univ. of Ma.				or Location of Dea More			ty of Death		
	Funeral		5. Social Security Number 214-32-0197	6. Sex 7. Ag 11⊠M 2□F	e (In yrs. last birtho 73 Yrs	Months Days			v. Year)	9. Birthp	place (State or ntry)	· Foreign
	Director		Usual Residence of Decedent		7.5			June 1	9 193	z Ma	rýlano	<u>a</u>
	yland		10a. State 10b. County	,	10c. City, Town o	r Location				1	10d. Inside Cit	
	a-fet	ctor	MD Ken	t	Worto	n					1 🗌 Yes	2 <u>X</u> No
	h with the 23a or 28	al Director	10e. Street and Number 24814 Smith	ville Rd.		10f. Zip Code 216	78		10g. Citizen of U • S •		ntry?	
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene. r then "neturel", or Items 23a or 28a-f ehow The Medical Examirational be rodified at	by Funeral	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Decedent Armed Forces ried 157 Yes 2  If Yes, Give Year or Dates:	Ever in U.S. No 1952 -1954	13. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2X No		Specify Yes or No rto Rican, etc.)	14. Ra Bl: Spec	ace - Americ ack, White, ify: Wh		
5-0	72 ha netur	Completed	15. Decede (Specify only highe	nt's Education est grade completed)	16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of wo	orking	16b. Kind of I			
21	Aithin ne.	щ	Elementary/Secondary (0-12)	College (1-4or	5+)				Resid			
2	77		12 17. Father's Name (First, Middle	l act)		Carpenter		me (First, Middle,	Const		cion	
and	otal Period	Be	Charles P.		r.			e Usilt		mo <sub>j</sub>		
Z	2 should and Men Is marke eumatic	2	19a. Informant's Name/Relation			failing Address (Stree	t and Number or R	lural Route Numbe	er, City or Town	n, State, Zir	Code)	21620
	s 1 and 2 should be filed f Health and Mental Hyg item 27 Is marked othe other treumatic event,		Robert U. Co		(son) 8	309 South	n Meado	wview D	r. Che	ester		
Je,	es 1 a of Hea fitern r othe		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pla		Date	20c. Location			
Baltimore,	9 = 0		1 🛣 Burial 2 □ Cremation `4 □ Donation 5 □ Other (	3   Removal from State		n Cemete		22/05	Wort	on, l	MD.	
alti	permit. Pa Departmer Importent any injury		21. Signature of Funeral Service	Lionsee	/	22. Name and Addr Galena F	ess of Facility	Home of	Step	hen 1	L. Sch	naecl
_	90 = 9		7	9	M00510	118 West	Cross	St. Gal	.ena,	MD.	21635	
			23a. Part Enter the disease, of shock, or heart failure. Lis	r complications that cause t only one cause on each I	d the death. Do not ne.	enter the mode of dy	ing, such as cardia	ic or respiratory ar	rest,		Approximate Interval Betwood	veen
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a Multip	le Injui	cies with	n Compli	cations	5 ~~		24 day	γs
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)			V	N			
		e.	Sequentially list conditions,	b. Due to for as	a consequence of			Total Edwinds				
V	nted Insit	in	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	<			J.	EDICAL E				
ζ,	te be executed ysician and e burial-transit	Examin	resulting in death) Last	c. Due to (or as	a consequence of)		1 1000					
760,	le be ysicia e bur	cal		d			PPROVI					
68	rtifica ng ph as th		I S S S W S			1	710					
Box	leath certificate b attending physic I for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal death	3 □Ectopic pregnance	ch Zz.			ate of delive	•	'ear
	e dea the at red fo	Sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant a 9☐Unknown		5 ☐ Other (specify)			l v	OHIII	Day Y	Bai
P.0	that the de thed by the a detached f		Part II. Other significant condit	inns contributing to death l	out not resulting in th	se underlying cause o	wen in Part I	23e Did to	obacco use co	atribute to t	he cause of de	eath?
ds,	or be	1 by	atti. Other signmount contain	to the contributing to death i	out not resulting in th	ie ditariying cadse gi	149.11111 (41(1.		∕es 2 <mark>X</mark> iNo			
Ö	w requir been si should	etec						24a. Was	20 24h	Wara auto	opsy findings a	aldelieu
Rec	The lav	Completed						autor		prior to co death?	impletion of ca	use of
Vital Records,		e Co	25. Was case referred to medic				26 Place of Do	1 ☐ Yes eath (Check only o		1 🗆 Yes	XI No	
5	Physicien: this certific ral director,	O B	examiner? X Yes 2 No	Hospital: X Inpati	ent 2   ER/Outpa	atient 3 DOA	ther: 4 \( \sum \) Nursing			ther (Specif	fv)	
of		n:T	27. Manner of Death	28a. Date of Inj	ury 28b. Tim	ne of 28c. Inju		28d. Describe I	now injury occu	urred		
Ö	Attending F r death. sctor: After by the funera	atlo	7.00100111	igation 7/24/0			Yes X□No	Motor	Vehic	:le A	ccide	nt
Division	or Attendater deatl	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be mined 28e. Place of In building, e	jury - At home, farm tc. (Specify)	, street, factory, office		28f. Location (S City or Tox				
	ital or saft rel Di	Cer		Road					nac Ro		291 a	
	Hosp 4 hou Fune ely fil	edical	(Check only 2 Medica	ng Physicien: To the best Exeminer: On the basis of	of examination and/o	death occurred at the toor investigation, in my	time, date and place opinion, death occ	e, and due to the	cause(s) and n	nanner as s	stated.	ЬM
	or or the Hospital or Attending 24 hours after de To the Funerel Directo completely filled in by the	Med	one)  29b. Signature and title of certifications of certifications of certifications of certifications of certifications on the certification of certifications of certifications of certifications on the certification of certifications of certific	and manner s	ared.	29c. Licen	ise number		29d. Date sign	ed (Month	Day, Year)	_
1	T S			1111		169			Aug 22			
,	1		30. Name and address of person	who completed cause of	death (Item 23a) (To	(ne Print)						
	CK1			ID 22 S. C	Greene S	treet, B	altimor	e, Mary	land 2	21201	-	
	Sta	at <u>e</u>	31. Date filed (Month, Day, Yea	) 32. Regist	rar's Signature							
, <b>&amp;</b>	Regist		AUG 2	9 2005	b -	1-1-						
DH	MH 17 Rev 1/2	001		June	in St.	CONTRACT OF THE PARTY OF THE PA						
	v				ORIGI	NAL						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Yeer 50/7 M S /Medical 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1**™**M 2□F Director 201-30-8732 Yrs. 64 Feb. 6, 1941 Tenn Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itema 23e or 28a-f show treumatic event, it e Madical Examinar must be notified at 1 ☐ Yes 2 No Director Delaware Sussex Seaford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 23843 Dove Rd. 19973 Completed by Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after to and Mental Hygiene. Is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced **Black**  Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) City of Elementary/Secondary (0-12) College (1-4or 5+) Health <u>Philadelphia</u> Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Robert Mamie Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 Ia m any injury or other treum once. Yvonne Coleman / wife 23843 Dove Road, Seaford Delaware 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 □ Removal from State White Chapel Gardens 08-22-2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Feasterville, Pa. 22. Name and Address of Facility Bennie Smith Funeral Home 717 W. Division Street, Lover, Delaware 19904 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHEMIC maron disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of) the attending physician hed for use as the buria Box 68760. Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ sate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 ☐ Yes 2 🔼 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗹 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year, 28b. Time of 28c. Certification: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Injury at Work? 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signa 30. N in e and address of person who completed cause of death (Item 23a) (Type, Print) PL BALTEMOR MID 32. Registar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Audrey Lucille Corbin August 11, 2005 7:35PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Min. 1 M 2 XX Yrs. Director 578-50-0556 67 January 1, Washington, D.C. Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show Itam 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic avent, the Madical Examination was be notified at St. Mary's Maryland Abell 1 ☐ Yes XXXVo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38799 Morris Point Road 20606 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Ā If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. important: if Itam 27 is marked other than "ne any injury or other traumatic avent, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter LaVern Coffren Maude Elizabeth McEachern ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Corbin / Husband 38799 Morris Point Road Abell, Maryland 20606 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/15/2005 Washington Nat. Cemetery Suitland, Maryland <sup>¹</sup> 4 □ Donation Ø ☐ Other (Specify) 22. Name and Address of Facility. George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** monic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 € 150 ğ Month Day Year 4 Pregnant at time of death P.O. 1 5 Other (specify) by the a detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ PS7 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 25 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Datural 2 Accident 5 Pending death. 1 Tes 2 No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by atter 4 - Homicide 24 hours a 29a. Certifier 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) To the within 2 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suratts Rel. Clinton-MD2073t Surer Partel m 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar AUG 1 5 2005

State Registrar 31. Date filed (Month, Day, Year) AUG 1 5 2005

Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 11, 2005

29b. Signature and title of certifier

(Check only one)

of death (It in 23a) (Type, Print)

			. For	State of Mar	yland / De	partment of I	Health and M	lental Hyg	iene_	
			State     Registrar      Decedent's Name (First, Middle, Legistranse)	and)	C	ertificate of	Death	2. Date of Dea	eg. No 200	5 28 68 3. Time of Death
	Physici		Edwin	Charles	C	allow			1,2005 Ye	
	/Medic Examin		4a. Facility Name (If not institution, g				or Location of Death		4c. County of D	
	-Xaiiiii	٠.	Laurel Region	al Hospita	1	Laur	el		Prince	e George's
	Funeral Director		578-40-2218	Sex 7. Age (	In yrs. last birthda 77 Yrs	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10/20	/1927 T	Birthplace (State or Foreign Country) Nash., D.C.
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or	Location				10d. Inside City Limits
	a-fah	ctor	MD Montgo	mery	Burto	nsville				1 ☐ Yes 2 <b>X</b> No
	th with the 23s or 28	Funeral Director	10e. Street and Number 4200 Woottens	Lane		10f. Zip Code 208	66	1	0g. Citizen of What USA	-
920	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or Items 23s or 28s-f ahow marked other than "natural", or Items 23s or 28s-f ahow maite event, the Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1946- 1947	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2文 No		ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	umerican Indian, White, etc. White
Maryland 21215-0036	within 72 ho ane. <b>than "natur</b> he Medical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed)  College (1-4or 5+)	(G life	ocedent's Usual Occupive kind of work done b. DO NOT use retire Plumber	pation during most of work d)	ing	16b. Kind of Busine Plumber Local #!	's Union
land 2	ed fa b	To Be Co	17. Father's Name (First, Middle, La John H. Callo	st) W			18. Mother's Nam Harrie	e (First, Middle, et Mari	Maiden Sumame) e Wagnei	r
Aary	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship		1.	ailing Address (Street				
	Health Health tem 27		Gloria M.Call 20a. Method of Disposition			Sposition (Name of crematory or other pla			20c. Location - City	e, Md 20866 or Town, State
E	Pages net of int: If i	,	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (如)		Chesar	peake Cre	em. 8/13	/2005	Beltsvi	lle,Md.
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lic	ensee P		PHTLTP <sup>dd</sup> 9241 Col	S.RINALD Lumbia B	I FUNER	RAL SERV Lver Spr	ICE,P.A. ing,Md20910
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	y one cause on each line		enter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Strok  Due to (or as a	consequence of):					4 days
n	Examiner		Sequentially list conditions,	0.	II Dia					10 yeras
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					10 years
Ć,	e be executed sicien and e buriat-transit	Exar	that initiated events resulting in death) Last	·	consequence of):					years
68760,		cai		d. Ische	emic Ca	rdiomyop	athy			10 years
P.O. Box (	Attending Physician: The law requires that the death certificate ir death. ector. After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the by the funeral director.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	delivery Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions	contributing to death but	not resulting in the	e underlying cause gr	ven in Part I.			e to the cause of death?  Probably 4  Unknown
Division of Vital Records,	The law re ate has bee page 2 sho	Completed						24a. Was a autops perform	ned? prior death	e autopsy findings available to completion of cause of 1? Yes 2 \sumbox No
/ita	ysician: The is certificate hadirector, page	Be (	25. Was case referred to medical examiner?	113-1			26. Place of Deat	h (Check only or	(e)	
of \	Physic this c	- To	1 ☐ Yes 2 🔀 No  27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpa	tient 3 DOA			ence 6 Other (S	Specify)
ono	Attending I st death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day	Year) 200. Illiu	ry Wo	rk? Yes 2 No	200. Describe in	ow injury occurred	
Divisi		Certification:	3 Suicide 6 Could not determine	28e. Place of Injury building, etc.		street, factory, office		28f. Location (Si City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of aminer: On the basis of e and manner state	xamination and/o	eath occurred at the ti r investigation, in my	ime, date and place, opinion, death occur	and due to the cored at the time, d	ause(s) and manner ate and place, and	r as stated. due to the cause(s)
)	To the within 2 To the complet	M	29b. Signature and title of certifier				3237	2	9d. Date signed (Me August	
	6		30. Name and address of person wh				<b>D</b> -		0.55	
	Sta	te	Paul Armstron 31. Date filed (Month, Day, Year)	.g MD 1420	s Signature	1 Park	υr. Laui	reı,Md	20/07	
	Registi		AUG 1 5	2005 Singua	s Signature	puli				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 28/69 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Richard Wentworth Dudley, Sr. 2005 7:00a August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Bethesda
If Under 1 Year If Under 24 Hrs. Eden Homes Assisted Living Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Months Days 1<sub>€</sub>M 2□F 214-03-8572 89 May 25, 1916 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland | Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 3501 Forest Edge Drive 2E 20906 USa 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify. 3 X Widowed 4 ☐ Divorced WW IIWhite 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chief Postal Accountant Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick E. Dudley Edna Giles Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie D. Brown 15308 Good Hope Road daughter Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery Aug. 2005 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Wille 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia 2 Days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 15, 2005 D24543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The law requires that the death certificate be executed the attending physician and ched for use as the burial-transit Division of Vital Records, P.O. Box 68760, funeral After within 24 hours after uccur...

To the Funeral Director:

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ral, or items 23a or 28a-f show Examiner must be notified at

'natural', or

than

Pages 1 and 2 should be nent of Health and Mentat

permit. Pages 1 and 2. Department of Health a Important: If item 27 Is any injury or other trau

**Physician** 

/Medical

Examiner

injury or other traumatic

9

Examiner

Physiclan/Medical

þ

Completed

Be

Certification; To

cal

Directo

Funeral

þ

Completed

Be

ဥ

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

15+1

To the

State Registrar

James A. Rossi, M.D. 31. Date filed (Month, Day, Year) AUG 1 5 2005



3305 N. Leisure World Blvd, Silver Spring, MD 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** AUGUST 10 2005 FLORENCE KIMMEL BURNSIDE EVANS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner I.A PI ATA MD.

If Under 1 Year 1 1 Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) CIVISTA MEDICAL CENTER
5. Social Security Number | 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Director 577-12-3360 Yrs FEB 18, 1918 Washington, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or itams 23e or 28e-f show the Medical Evantiner must be notified at 1 ☐ Yes 3√☐ No Maryland Charles Swan Point Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11310 Ethan Court 20645 USA hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Completed by 3√2 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator US Government 12 is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event 90cs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel B. Burnside Adah Kimmel Burnside 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11310 Ethan Court Swan Point, Maryland Ronald B. Mock (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burian 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens 8-15-05 Waldorf, MD 5 Other (Specify) heral Service/Licenses 22. Name and Address of Facility 21. Signature of Fu Eberwein Funeral Services M00173 4433 White Pls. La. White Pls., MD 20695 MAN 1. Enter the spease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In rediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA EW DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liseage or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 DaNo
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Cther (specify) 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PulmonAry CHRONIC OBSTRUCTURE D13580-1 ☐ Yes 2 ☐ No 3 ☐ Probably ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 📜 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 112. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dato and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dav. Year) all 2005 D-44436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD 102 PAUL MELLON COURT SUITE 102 WALDORF MD 20602
32. Reg Par's Signature PATEL, ASHVINKUMAR J.,

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

EVANS Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygien 2005 28171 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August Day 12, **Physician** Mary F. Evcic 2005 4:44A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 24, 1933 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 J 200-26-7423 71 Yrs Pennsylvania Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinet must be nutified at Maryland Prince George's Clinton 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6804 Crafton Lane 20735 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Justice Department Legal Secretary Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas W. Kasubick Leona A. Panzak ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Evcic -husband 6804 Crafton Lane Clinton, Maryland 20735 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holy Trinity Catholic Cem. 8/16/2005 Ramey, PA. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 womas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence **Examiner** Decubitus alcers ected dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ n101 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl 2 **2** No 1 Yes To the Hospitel or Attending Physicien: : After this certification of funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X npatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ☐ Accident Director: / 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surratts Rel 10 Partel res M 31. Date filed (Month, Day, Year) AUG 1 32. Registrar's Signature State 15 2005 20016

Registrar

		-	For State Registrar	State of Man	•	artment of H			iene •g. No:2005	28172
	Physici	an	Decedent's Name (First, Middle, Last     JULIA MAY	FRYE				2. Date of Deat Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	AUGUST	12 2005 4c. County of Dea	0.10 1
	Examili	el	COLLINGSWOOD NUR			ROCKVI			MONTGO	MERY
	Funeral Director		5/9-24-9651	TM 257 F	n yrs. last birthday) 30 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Day	9. Bir 7 1924 Was	rthplace (State or Foreign ountry) shington, D.C.
	yland		Usual Residence of Decedent  10a. State  10b. County		0c. City, Town or Li					10d. Inside City Limits
	Ba-f s	ector	Md. Montgo	mery	Silver	Spring			0-00-00	1 Tyes 25 No
	3a or 3	Dir.	10e. Street and Number 3591 S. Leisure	World Blvd	•	10f. Zip Code	20906		Og. Citizen of What C United S	-
36	i within 72 hours after death with the Maryland liene. I than "neturel", or Itams 23a or 28a-f show The Medical Evar, invertional be notified at	by Funeral Director	11. Marital Status  ↑ Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13. Korean	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pue Specify:	Specify Yes or No- orto Rican, etc.)	0	
21215-0036	within 72 hou ene. than "neture he Medical E	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of w	orking	16b. Kind of Business	s/Industry
			12	1	Acc	ounting C				Sovernment
Maryland	ed fa by	o Be	17. Father's Name (First, Middle, Last) $Marion F.$	Frye			Mary	ame <i>(First, Middle, I</i> Elizabe		
ary	sho s me	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ing Address (Street a	and Number or i	Rural Route Number	r, City or Town, State,	Zip Code)
	of Health item 27 i		Carolyn F. Greath  20a. Method of Disposition						r Spring, 20c. Location - City of	
nor	80= 5		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Hemovai irom State		osition (Name of matory or other plac itan Crem		14/05	Alexandri	
Baltimore,	arth orte inju		21. Signature of Funeral Service Licens		2	2. Name and Address Muriel H.	s of Facility			a, va.
8	Ded Imp gany		23a. Part1. Enter the disease, or comp	· Bark		P. O. Bo	$\times$ 5038,	Laytonsv	ille, Md.	20882 Approximate
	Pnysician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Small Due to (or as a c	Cell	Lung				Interval Between Onset and peath
8760,	ate be exacuted hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c						
O. Box 6	The law requires that the death certificate be exacuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2a□ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [ 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
Δ.	quires that n signed b ıld be deta	by	Part II. Other significant conditions co	ontributing to death but r	not resulting in the t	underlying cause give	en in Part I.		bacco use contribute t es 2 □ No 3 □ P	to the cause of death?
i Records,		Completed						24a. Was a autops perfor	sy prior to	utopsy findings available completion of cause of
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		- scape Othe		eath (Check only or		
of	ding Phys	tlon; To	1 Yes 2 No  27. Manner to th  1 Vatural 5 Pending investigation	28a. Date of Injury (Month, Day Y		of 28c. Injury Work	4 ₩ mursing ⁄at		ence 6  Other (Spe ow injury occurred	ecify)
Division	al or Attendis s after death. of Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (		treet, lactory, office		28f. Location (S City or Town	treet and Number or R n, State)	Rural Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Ph. 2 Medical Exam	ysician: To the best of r iner: On the basis of ex and manner state	camination and/or in	nvestigation, in my o	pinion, death oc	curred at the time, d	late and place, and du	e to the cause(s)
	To t To t	ž	29b. Signature and title of certifier  Another	ama		DOO	536)5		19d. Date signed (Mon August, 13	e MD 2083 2
	10+1			ompleted cause of dea	th (Item 23a) (Type 1125 Ro	CRVILLE P	ike, Su	ite 208	Rockyi)	e MD 20852
•	Sta Regist		31. Date liled (Month, Day, Year) AUG 1 5 2	32. Aegistrar's	s Signature	parte				

State of Maryland / Department of Health and Mental Hygiene 2005 28173 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 7:30P N 2005 11, FELDMAN 4b. City, Town, or Location of Death August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Mariner Healthcare Laurel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 29, 1964 5. Social Security Number 215–80–6986 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 41 1 M 2 K Yrs. Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show other traumatic event, the Madical Exercit are rust be notified at Bowie Maryland Prince George's 1X Yes 2 No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number WIT 20715 12200 Malta Lane United States Items 23a Be Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced 'neturel', Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Shirley Nelson Joseph G. Feldman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Feldman -mother 12200 Malta Lane Bowie, Maryland 20715 item 27 i Date 20a. Method of Disposition
1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State of . MD Veterans Cemetery 8/12/2005 Cheltenham, Maryland ŏ Department of Importent: If any injury or 9 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 21. Signature of Fr Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter Immediate Cause (Final disease or condition resulting in death) Down's Syndrome years Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisassor is jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year ō 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Quadraparesis; respiratory failure 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2X No 2 🗆 No 1 Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Medical Certification: Division 5 Pending investigation 1 Tes 2 No М death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 | Homicide within 24 hours a To the Funeral I 1🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) August 12, 2005 License number 29b. Signature and title of certifier D24721 35 Nerd and Saddison PM. D. 974333 Laurel (10 Bowie Rd.), #208 Laurel, Maryland 20708 32 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 5 Coart State 2005 Registrar

			State of Maryland / Dep				00171
			1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg	2005	3. Time of Death
п	Physici		John Thomas Goheen		Month August	Day Year 15, 2005	7:00 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1 0	4c. County of Death	1
			6245 Tamar Drive	Columbia If Under 1 Year If Under 24 Hrs.	1	Howard	
н	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 160-30-1782	If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.	8. Date of Birth (Month, Day, ) May 28,		place (State or Foreign ntry) ISYIVania
	D.		Usual Residence of Decedent		may 20,		
	ahow ahow	2	10a. State 10b. County 10c. City, Town or to Maryland Howard Columbia	ocation			0d. Inside City Limits 1 ☐ Yes 2 XNo
	28a-f	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	
	h with		6245 Tamar Drive	21045		JSA	
	ems sermin	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White,	
36	hours after death with the Maryland tural; or frems 23a or 28a-f ahow al Evaninar must be notified at	by Fu	1 □ Never Married 227 Married 1270 Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1957 – 63	1 ☐ Yes 2X No Specify:		Specify: Whit	
00-	72 hou natural dical E		15. Decedent's Education 16a. Dece	edent's Usual Occupation	16	6b. Kind of Business/In	
218	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "natural", or flems 23a or 28a-f ahow other than "natural", or flems 23a or 28a-f ahow event, the Madical Examinar must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing		
121	filed w Hygier other th		1 Serv. 17. Father's Name (First, Middle, Last)	ice Manager	e (First, Middle, Ma	Auto Repair	
Maryland 21215-0036	should be f nd Mental I marked oi	To Be	John Thomas Goheen	Marie Wi		addir damario,	
ary	2 should and Men is marke sumatic	۲		ing Address (Street and Number or Run			Code)
	and ealth n 27 ser tr			Tamar Drive Colum			
more	Pages 1 nent of H int: If iter iry or oth		11 Burial 2 A Cremation 3 Hemoval from State 1	omatory or other place) Aug e1 Crematory 20		oc. Location - City or To lenton, Mar	
Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licensee/	2. Name and Address of Facility oing Home Crematio everly L. Heckrott	n Service	P.O. Box	784
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.				Approximate Interval Between 1
	Physician		Immediate Cause (Final	rrythmia s	udden	cleath	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		ol. C.		1100
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ereore heart	CNIZE	240	410,
	cuted	Examin	that initiated events	wo the rosc	leros	40	VIRS
50,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):				ı
68760,	physicate to physical	dlcal	d				
Box (	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3			23d. Date of delive	ery
.O. B	the death carificate be executed y the attending physician and iched for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		Month	Day Year
٥	that the de led by the a detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
rds	quires an signa uld be	ed by	History, myocarchal Interest	0, Hyperpoide	YWW TO Yes	2 No 3 Prob	ably 4 Nurknown
Vital Records,	The law requires that te has been signed b bage 2 should be deta	Completed	Hypertensin		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u>=</u>		Соп			performe	ed? death?	
Vita	Phyalcian: T this certifical ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other	h (Check only one)		
of		-	27. Manner of Death 28a. Date of Injury 28b. Time (	TIL 30 DOX 40 INGISING TRO	28d. Describe how	ce 6 Other (Specification of the control of the con	//
sior	Attending Product death. sctor: After by the funera	catlo	2 Accident investigation	M 1 Yes 2 No			
Division	in Direct	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	I Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dire completely filled in the completely filled in the completely filled in the funeral Direction of the funeral Dir	ledical C	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, deal (Check only one)  1 Medical Examiner: On the basis of examination and/or is and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau red at the time, date	se(s) and manner as s e and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, gust 15, 20	Day, Year)
/	DX!		30. Name and address of persony the completed cause of death (Item 23a) [Type	Print) A	Aug	1110011	Dy
	2/26		Mehin Kordan MD, 9501 Ol	1 silogenna 1	M Gan	pryland	21044
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 6 2005  32. Figistrar's Signature	book		•	

				epartment of Health and No Certificate of Death	Mental Hygid	ene 2005	
	Physici		1. Decedent's Name (First, Middle, Last)  Charlotte D. Gi	reenwood	2. Date of Death Month August 1	.3 <sup>Day</sup> 2005 <sup>Year</sup>	3. Time of Death 7:30 AM
L.	/Medic Examin		4a. Facility Name (If not institution, give street and number) 9015 2nd Street	4b. City, Town, or Location of Death  Lanham		4c. County of Death	
l	. Funeral Director		5. Social Security Number 019-01-0150 6. Sex 1 □ M 2 F 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, ) July 14,	1903 Mas	pplace (State or Foreign intry) SSACHUSETTS
	yland sow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
	e Man Be-f sh	ctor	Maryland Prince George's	Lanham			1 XYes 2 No
	ath with the Marylar s 23s or 28e-f show	Funeral Directo	10e. Street and Number 9015 2nd Street	10f. Zip Code 20706	100	g. Citizen of What Cou USA	•
	ems 23	nera		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	ican Indian,
36	rs after	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes ŽŪ No Specify:	Triodit, 6(0.)	Black, White	
9500-61212	filed within 72 hours after death with the Maryland Hygiene. uther then "netural", or Items 23s or 28e-f show ant, the Medical Examinat must be redified at	ted t	15. Decedent's Education (Specify only highest grade completed) (6	ecedent's Usual Occupation Give kind of work done during most of work	ing 16	6b. Kind of Business/I	
12	within ane.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)  Secretary	ang	Private	
		Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
Maryland		ToE	Walter F. Lufkin		riella F.		
Ma	d 2 7 is		19a. Informant's Name/Relationship (Type, Print) Natalie Serrin (Daughter)  19b. N 90	Mailing Address (Street and Number or Rur 15 2nd Street, Lanha	al Route Number, C am MD 207	City or Town, State, Z. 06	ip Code)
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		20a. Method of Disposition 1   20b. Place of Disposition 1   20b. Place of Disposition 3   20b. Place of Disposition cemetery,	Disposition (Name of crematory or other place)	Date 20	Oc. Location - City or T	own, State
Ē	it. Pag intment intent: injury o			rook Cemetery 8/19		loucester,	
r R	Departing Polysian Po		Munchenson	22. Name and Address of Facility Rep 9013 Annapolis Road			
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	t enter the mode of dying, such as cardiac diel In Farction	or respiratory arres	t,	Approximate Interval Between Onset and Death
Ē	/Medical Examiner		Sequentially list conditions b. Atheroscl	erotic Vascular	Diseas	se	Years
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ension			Years Years
Ď,	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of)				16003
68/60	icate by physic s the bu	dicat	d				
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ≯© No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	very Day Year
1	uires that signed by Id be deta	by	Part II. Dther significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.		cco use contribute to	the cause of death?
Vital Hecords,	m _ m	Completed			24a. Was an autopsy performs	prior to co death?	opsy findings available ompletion of cause of
Ţa Ta	sician: The certificate rector, pag	Be Co	25. Was case referred to medical examiner?	26. Place of Deat	1 ☐ Yes 2X h (Check only one)	No 1 ☐ Yes	2 No
	Physic this ceral dire	2	Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4 Nursing Ho		ce 6 Other (Spec	fy)
O	ntending l death. ctor: After y the funer	ation	27. Manner of Death    San Date of Injury   28b. Time		28d. Describe how	injury occurred	
Division of	or At fler c Direct in by	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town,	et and Number or Rui State)	al Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, or and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as a e and place, and due	stated. to the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	29c. License number		I. Date signed (Month)	
Λ	(In)		30. Name and address of person who completed cause of death (Item 23a) (Ty	D37934		3/14/200	
_	10)		Stephanie Tifoglia, MD 7500	Greenway Center Dr	ive #430	Greenhaltm.	26770
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Ty Stephanie Trifosli <sup>2</sup> MD 7500 31. Date filed (Month, Day, Year)  AUG 15 2005	mole			

		1	For State Ragistrar	State of Mai		ertificate of		Mental Hyg	iene ag. No. 20	05	281	76
	7	ij.	Decedent's Name (First, Middle, La	st)				2. Date of Deat	h		3. Time of 0	Death
	Physicia		William Lou	is Herber	t			AUGUST	20, E	Year (21215	12:20	1 FM
	(Medic Examin		la. Facility Name ( <i>If not institution</i> , giv Saint Joseph	re street and number)		4b. City, Town, o	r Location of Death TOWS		4c. County		.more	
	Funeral Director		5. Social Security Number 6. S 212-30-1610	Sex 7. Age 1 M 2 □ F 7 2	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 16,	<sup>Year)</sup> 1933	Coun	lace (State or itry) yland	Foreign
	פ	H	Usual Residence of Decedent								Od Incide Cit	. I imite
	irylan show		10a. State 10b. County		10c. City, Town or i					1	0d. Inside City 1 ☐ Yes	
	Ba-f s	Director	MD Baltim	ore	Freela				0g. Citizen of \	Mhat Caus		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic evant, The Medical Examinat must be rigitled at		10e. Street and Number 315 Old Free	land Road	l	10f. Zip Code 2105	53		U.S.A			
<b>'</b>	fter dea	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent En Armed Forces? 1 ZYes 2 ☐ No		. Was Decedent of H	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Blac	e - Americ ck, White,		
21215-0036	hours a tural', o	þ	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates: K		1 ☐ Yes 2X No edent's Usual Occup	Specify:		Specify 16b. Kind of B	WII	ite	
215-	thin 72 e. an "nat	Completed	(Specify only highest gr Elementary/Secondary (0-12)	Coilege (1-4or 5+	(Giv	e kind of work done DO NOT use retire	during most of word)	king				
	ed wii	ទ	7		Tru	ck Drive		ne (First, Middle, I	Stone		атту	
land	ild be fill fental H rked oth	To Be	17. Father's Name (First, Middle, Last John W. Herk					ta A. M				
Maryland	12 should the and Men 7 is marke traumatic		19a. Informant's Name/Relationship William M. Hea			iling Address <i>(Street</i> 0 Grave						
Baltimore, I	permit. Pages 1 and 2. Department of Health ar important: If itam 27 is any injury or other traugnce.	1	20a. Method of Disposition  1    Burial 2 □ Cremation 3   [ Cremation 3 ]		20h Place of Dis			Date 25,	20c. Location -	· City or To	own, State	
Ē	Pag tment tant: I		4 □Donation 5 □Other (Special	ify)	Methodis	t Cemeter 22. Name and Addre	y 200	5	Parkto			Enc
Ba	permii Depar Impol any ir		21. Sign state of Purieral Service Lie	arteus	sui !	24 Secon	d St., I	New Free	dom,	PA 1	7349	
			23a. Part. Enter the disease, or conshiper, or heart failure. List only	nplications that caused to y one cause on each line	he death. Do not e	nter the mode of dyi	ng, such as cardiad	or respiratory arr	est,		Approximate Interval Betw Onset and D	veen
H	Priysician		Immediate Cause (Final disease or condition resulting in death)	_ a		C ANEUR	/SM			H	IOURS	
	/Medical Examiner				consequence of):							
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):							
Ć	death certificate be executed  e attending physician and  od for use as the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):							
8760,	ate be hysicia the bur	dlcal		d								
9	ertific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of	f pregnancy				23d Da	te of delive	20/	
. Box	death certifics e attending pl d for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1⊡Live birth 2 4⊡ Pregnant at t	Fetal death	B Ectopic pregnand  Other (specify)				onth	,	'ear
P.0	that the de led by the a detached t	hys	9 🗆 Unknown	9□ Unknown				00 8:11				
	9 P 9	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.		bacco use con es 2. No			
Records,	aw Is b	ompleted						24a. Was a autops	SV.	prior to co	psy findings a	available ause of
Ä	ate pag	Com						perform 1 ☐ Yes		death? 1 ☐ Yes	2 <b>X</b> No	
Vital	ician: T	Be	25. Was case referred to medical examiner?	IIit-l				ath (Check only or	10)			-
of	Physician: this certific ral director,	2	1 ☐ Yes 2 X No	Hospital: 1' Inpatier		ient 3 DOA		lome 5 ☐ Reside			(y)	
ion	After	atlon;	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day)	Year) 28b. Time Year) Injur	/ Wo	nyat ork? ]Yes 2∐No	28d. Describe in	ow injury occur	180		
Division	or Attandi after death. I Diractor: A d in by the fu	Certification;	3 Suicide 6 Could not 4 Homicide determine		ry - At home, farm, . (Specify)	street, factory, office		28f. Location (S. City or Town		per or Rura	al Route Numi	ber.
	Hospita 4 hours Funara ely fille	Medical Co	29a. Certifier (Check only one)  1 Certifying F	Physician: To the best of aminer: On the basis of and manner sta	examination and/or	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occi	e, and due to the curred at the time, d	ause(s) and malate and place,	anner as s and due to	tated. the cause(s)	)
	To the I within 2 To tha I complet	Me	29b. Signature and title of certifier	N. Committee			se number	2	9d. Date signe	d (Month.	Day, Year)	
			30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Tur		00Z		0121			
	10x,		JOHN H EPPLEF	•		01 OSLE	R DRIVE	TOWSON	MARYL	AND	21204	
	St. Regist	atė			r's Signatur		T too Y Eggs	The same same same same same same same sam				
	riegisi			7								

		-	For State Registrer	State of Ma			rtment of He tificate of D			iene 20	05	28177
	Physici	4.2	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic	al	Edna Katherine H						August			4:00 A M
	Examin	ęr	4a. Facility Name (If not institution, give s				4b. City, Town, or Lo	ocation of Death	Aug		nty of Death	
		Rus .	Waldorf Health C		e (In yrs. last bin	thday)	Waldorf If Under 1 Year	f Under 24 Hrs.	8. Date of Birth	Char		place (State or Foreign
Н	Funeral Director			M OFF	, -	Yrs.	Months Days	Hours Min.	May 30	1915	Alaba	place (State or Foreign ntry) ama
	ס		Usual Residence of Decedent									
	arylar show	_	10a. State 10b. County		10c. City, Town		cation				1	0d. Inside City Limits 1    Yes 2   No
	he M	ectc	Maryland Charles  10e. Street and Number		Waldor		10f. Zip Code		1.	IOa Citizon o	of What Cour	21
	with is or i	Ö	4140 Old Washing	ton Road			20601			rog. Omzen c	USA	iu y :
	ms 23	Funeral Director		2. Was Decedent	Ever in U.S.	13. V	Vas Decedent of Hisp Yes, specify Cuban,		ecify Yes or No-		Race - Americ	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinational be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:	No			Specify:	Hican, etc.)		Black, White, c <i>ify:</i> Whi	
2-0	72 ho natur	Completed	15. Decedent's Educ	ation completed)	16a.	(Give	ent's Usual Occupation	on ring most of work	ing	16b. Kind of	Business/In	dustry
21	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5		lite. L	OO NOT use retired)			Food	Sa10	
	e filed within at Hygiene. other than '		17. Father's Name (First, Middle, Last)		0	ler		8. Mother's Nam	e (First, Middle,			
ano	Mental Mental arked o	To Be	William Thomas						Fincher			
Maryland	should be ind Mental is marked o	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b	. Mailin	g Address (Street and					Code)
	1 and 2 s Health ar tem 27 is		Joan Hornsby (Daug	hter)	. 20	7 B	arksdale A	Ave. Wal	dorf, M	20602	2	
ore	of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R		20b. Place of cemeter	f Dispor	sition (Name of natory or other place)		Date	20c. Location	n - City or To	own, State
Ē	Pages ment of tant: If it		`4 ☐ Donation 5 □ Other (Specify)		Hillv	iew	East Cem	8–17	-	LaGran	nge, G	eorgia
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Ameral Solvice circense	en MC	00173	<sup>22</sup> 50	Name and Address Hill St.	of Facility Hun LaGrand	ter-Alle ge, GA.	n–Myha 30241	and F.	н.
	, ,		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do i	not ente	er the mode of dying,	such as cardiac	or respiratory are	est,		Approximate Interval Between
1	Pnysician		Immediate Cause (Final disease or condition	Cerebra	vescula	r a	ccident					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):						
Ų.		<u></u>	Sequentially list conditions, If any leading to immediate		a constiuence							years
	nted Insit	Examine	cause. Enter Underlying Cause (Disease or injury	- 00 (210.00								
Ć,	icate be executed physician and s the burial-transit	Exa	that initiated events cresulting in death) Last	Due to (or as	a consequence	of):						
68760,	te be ysicia na bur	edicai										
_	+ C 2		IF FEMALE:									
P.O. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes No 9  Unknown	3c. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				Date of delive Month	ory Day Year
	res that signed b	by Pi	Part II. Other significant conditions con	tributing to death b	ut not resulting in	n the ur	nderlying cause given	in Part I.	23e. Did to	bacco use co	ontribute to th	he cause of death?
ırdş	w require been sig should b		Demention		· · · · · · · · · · · · · · · · · · ·				1 🗆 Y	es 2□No	3 ☐ Prob	pably 4 Unknown
of Vital Records,	e law re has be ge 2 sho	Completed	hing mais - 1	probable	lung co	ance	er .		24a. Was a		b. Were auto	psy findings available impletion of cause of
H.	The ate h page	Con	Parkinsonium		•				perfor	med? 2 □ No	death? 1  Yes	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:					h (Check only or			
of	Phys this al di	은	1 ☐ Yes 2 No	28a. Date of Inju	ent 2 ER/Ou	tpatien		4 Minurally H	ome 5 Resid			y)
O	ling After fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	njury	28c. Injury a Work? M 1 ☐ Ye	s 2 No	200. 00001100 11	ow inquity ooo	41104	
Division	il or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be			ırm, str	eet, factory, office				mber or Rura	al Route Number,
ó	s after	Cert	4  Homicide determined	building, et	c. (Specify)				City or Tow	n, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one) 2 Medical Examin	ician: To the best ter: On the basis o and manner sta	f examination an	e, death	occurred at the time, restigation, in my opin	, date and place, nion, death occur	and due to the d red at the time, o	ause(s) and late and place	manner as si e, and due to	tated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier				29c. License r		2		ned (Month,	Day, Year)
)			M Cat	w.			0535	5-		08/15	5/05	
5	B		30. Name and address of person who co				Print) { C7A 575	NO CUA	LOUNEM	0 206	102	
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		1 0					
	Registi	ar	AUG 1 5 20	UD See	va #	19	parke					

Physic	ian	Decedent's Name (First, Middle,		1100110			Date of Deat     Month	Day	Year	3. Time of Death		
/Media		VIUIE	HORUS  4b. City, Town, or Location of Death			August	9 20	005	4:55 Pm			
Exami	ner	4a. Facility Name (If not institution, Prince George's				or Location of never1			4c. County		Coomania	
Funeral			6. Sex 7.	Age (In yrs. last birthda	y) If Under 1 Yea	r If Under	24 Hrs.	8. Date of Birth		9. Birthol	George's	
Director		579-20-5747	1□M 2QF	93 Yrs.	Months Days	s Hours	Min.	Dec. 30	, 1911	Sout	n Carolina	
* 1		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					10	0d. Inside City Limits	
le da	ţō	Maryland Princ	e George's		oitol Hei	ghts					1∭Yes 2☐No	
r 28e	Director	10e. Street and Number	000180	<u></u>	10f. Zip Code			1	0g. Citizen of V	g. Citizen of What Country?		
23a c	a D	4803 Addison Ro	oad #201		2074	43			USA			
s met	Funeral	11. Marital Status	ent Ever in U.S. 13 es? XNo	B. Was Decedent of If Yes, specify Cu		gin? (Spe	ecify Yes or No- Rican, etc.)	14. Rac	14. Race - American Indian, Black, White, etc.			
ro.	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	1	1 ☐ Yes 2 🗓 No	o Specify:			Specify	Specify: Black			
one than "netural", or Items 23a or 28e-f show the Medical Examinar must be notified at	ted	3. ⚠ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation					. 3.5		16b. Kind of Br	Sb. Kind of Business/Industry		
Med "n	Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)						ing				
Hygiene.		5 Housewife								Private		
a p &	Be	17. Father's Name (First, Middle, L.) Pettie Stro	•			1		e (First, Middle, M		16)		
and Ment is marked	To	19a. Informant's Name/Relationshi		19b. Ma	iling Address (Stree	Nett		McKi		State Zin	Code)	
27 is	1	Bernard Horne	(So:		Hollydal						20744	
Item 27 other tr		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pl			-	20c. Location -			
Department of I Important: If Its any injury or o		1  Burial 2  Cremation 3  Control 2  Cremation 3  Control 2  Control 3  Control 2   Control 2   Control 2   Control 2  C		210	Memoria1		8/16	5/ 2005	Landove	er, M	D	
Depart Import any inj once.		21. Signature of Foneral Service L	Ce)see		22. Name and Add			rdan Fur				
10 E 8 9		1)//	976		4001 Benn					, DC	20019	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiration arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death										
nysician /Medical												
		resulting in death)	a	The second secon	ionia S	epsis				WER	Interval Between Onset and Death	
	Н	resulting in death)	a	ation Proud as a consequence of):	ionia S	epsis		Mul		MER	Interval Between Onset and Death	
caminer	Jer	resulting in death)	Due to (or	The second secon	<del>onia</del> S	epsis	Mari	JON AT ROYED BY		MER	Interval Between Onset and Death	
aminer	amlner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a consequence of): as a consequence of):	ionia Se	<b>epsis</b>	ERTIFICAT	JON A FROMED BY		WER	Interval Between Onset and Death	
aminer	i Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence of):	<del>ionia</del> Si	epsis	ERTIFICAT	MIL NON THE NED BY		WER	Interval Between Onset and Death	
xaminer	dicai	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a consequence of): as a consequence of):	ionia Se	<b>epsis</b>	ERTIFICAT	JON AT PRIVED BY		WER	Interval Between Onset and Death	
xaminer	dicai	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or c. Due to (or d. 23c. If yes, outco	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy			ERTIFICAT	MIL BY FROMED BY	MEDICALEXAM		Onset and Death	
utending physician and cruse as the burial-transit	dicai	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or Due to (or d. 23c. If yes, outco	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy  1 2 Fetal death  2 Fetal death	BEctopic pregnan		ERTIFICAT	JON AT PRIVED BY	MEDICAL EXTENSION NEDICAL EXTE	te of delive	Onset and Death	
xaminer	dicai	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	b. Due to (or  c. Due to (or  d.  23c. If yes, outco	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy  1 2 Fetal death  2 Fetal death	3 □Ectopic pregnan		ERTIFICAT	ION IN PROVED BY	MEDICAL EXTENSION NEDICAL EXTE	te of delive	Onset and Death	
xaminer	Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2 No	Due to (or b. Due to (or c. Due to (or d.  23c. If yes, outco	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy  1 2 Fetal death  2 Fetal death  3 th but not resulting in the	B□Ectopic pregnan □ Other (specify) underlying cause g	су		23e. Did tob	NEDICAL EXTENSION NEDICAL EXTE	te of deliver	ry Day Year e cause of death?	
xaminer	Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or  b. Due to (or  c. Due to (or  d. 23c. If yes, outco 1 Live birt 4 Pregnar 9 Unknow  ons contributing to dear  Dunt Or	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy  a 2 Fetal death  at at time of death  the but not resulting in the	B Ectopic pregnan C Other (specify) underlying cause g	cy given in Part I.		23e. Did tob	MEDICAL EVAN	te of deliver	onset and Death  ry Day Year	
is bren signed by the attending physician and solid be detached for use as the burial transit	Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or  b. Due to (or  c. Due to (or  d. 23c. If yes, outco 1 Live birt 4 Pregnar 9 Unknow  ons contributing to dear  Dunt Or	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy  1 2 Fetal death  2 Fetal death  3 th but not resulting in the	B Ectopic pregnan C Other (specify) underlying cause g	cy given in Part I.		23e. Did tob 1 ☐ Ye S <b>Q</b> 24a. Was a autops	23d. Da Mo  Dacco use cont as 2 No	te of deliverenth	ry Day Year e cause of death?	
ate has been signed by the attending physician and page 2 st ould be detached for use as the burial-transit	Completed by Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2  No 9 Unknown  Part II. Other significant condition  Pacudomoneal Wo	Due to (or  b. Due to (or  c. Due to (or  d. 23c. If yes, outco 1 Live birt 4 Pregnar 9 Unknow  ons contributing to dear  Dunt Or	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy  a 2 Fetal death  at at time of death  the but not resulting in the	B Ectopic pregnan C Other (specify) underlying cause g	cy given in Part I.		23e. Did tot 1 ☐ Ye 24a. Was a	23d. Dar Mo	te of deliverinth  tribute to th  3  Proba  Were autoprior to condeath?	ry Day Year e cause of death? ably 4 Munknown	
ate has been signed by the attending physician and page 2 st ould be detached for use as the burial-transit	Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1   Live birt 4   Pregnar 9   Unknow ns contributing to deal bund Infection  Enfection	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy	B Ectopic pregnan Other (specify) underlying cause g es rdiovascu	cy given in Part I.  1lar D: 26. Place	iseas	23e. Did tob  1	23d. Dal Mo  23d. Dal Mo  23d. Dal Mo  24b. 1	te of delivering the control of the	ry Day Year  e cause of death? ably 4 X Unknown Day findings available inpletion of cause of 2 X No	
this certificate has been signed by the attending physician and related director, page 2 st ould be detached for use as the burial-transit	To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1   Live birt. 4   Pregnar 9   Unknow ns contributing to deal bund Infection Hospital: 1   Mange	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy	B   Ectopic pregnan   Other (specify)   underlying cause g   es   rdiovascu	given in Part I.  11ar D: 26. Place	iseas	23e. Did tob  1	23d. Dar Mo  23d. Dar Mo  Dacco use cont as 2   No no  No  No  24b. No  e)  ance 6   Oth	te of delivered to the state of	ry Day Year  e cause of death? ably 4 X Unknown Day findings available inpletion of cause of 2 X No	
this certificate has been signed by the attending physician and related director, page 2 st ould be detached for use as the burial-transit	To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1   Live birt. 4   Pregnar 9   Unknow  ound Infection  Hospital: 1   X Ing. 28a. Date of (Month,	as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy	B Ectopic pregnan Other (specify) underlying cause g es rdiovascu ent 3 DOA of 28c. Inj	given in Part I.  11ar D: 26. Place	iseas	23e. Did tot  1	23d. Dar Mo  23d. Dar Mo  Dacco use cont as 2   No no  No  No  24b. No  e)  ance 6   Oth	te of delivered to the state of	ry Day Year  e cause of death? ably 4 XIUnknown osy findings available inpletion of cause of 2XI No	
this certificate has been signed by the attending physician and related director, page 2 st ould be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  Pacticlomoneal Western Syndrome  Urinary Tract I  25. Was case referred to medical examiner? 1   X'es 2   X'es    27. Manner of Death 1   Xinarus   5   Pending	Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1   Live birt. 4   Pregnar 9   Unknow ns contributing to deal bund Infection Hospital: 1   Mange 28a. Date of (Month, atton	as a consequence of):  as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy  n 2   Fetal death  it at time of death  it at time of death  clerotic Ca  tatient 2   ER/Outpat  Injury  Day Year)  28b. Time  Injury  Day Year)	ent 3 DOA of 28c. Inj.	26. Place ther: 4 Nu ury at ork?	iseas	23e. Did tot  1  Yes  24a. Was a autops perform 1  Yes 2  1  (Check only on me 5  Reside 28d. Describe ho	23d. Dar Mo  23d. Dar Mo  Dacco use cont as 2   No no  Pare 24b.  Pare 27 No  Pare 6   Oth ow injury occurr  reet and Numb	te of deliverenth tribute to the stribute to the stribute to the stribute to condeath?	ry Day Year  e cause of death? ably 4 XUnknown osy findings available npletion of cause of 2XI No	
Ifter death.  Ifter death.  Director: After this certificate has bren signed by the attending physician and bin by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Due to (or d.  23c. If yes, outco 1 Live birt 4 Pregnar 9 Unknow  as contributing to dear  Cund Infection  Hospital: 1 Infection  Hospital: 28a. Date of (Month, ation of be ned 28e. Place of building	as a consequence of):	B Ectopic pregnan G Other (specify) underlying cause g es rdiovascu  ent 3 DOA of 28c. In W M 1[ street, factory, office	26. Place 26. Place ther: 4 \( \) Nu ury at ork? \( \) Yes 2 \( \)	iseas e of Death rrsing Hon	23e. Did tob  1  Ye  24a. Was a autops perform 1  Yes 2  1  Check only on me 5  Reside 28d. Describe ho  28f. Location (St. City or Town	23d. Dar Mo  23d. Dar Mo  Dacco use contras 2 No  n your No  e)  Pance 6 Oth Davinjury occurr  reet and Numb	te of delivering the control of the	ry Day Year  e cause of death? ably 4 X Unknown Day findings available in position of cause of 2 X No  Route Number,	
Fundamental Comments of the fundamental director, page 2 st ould be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1	as a consequence of):	B   Ectopic pregnan   Other (specify)   underlying cause g   es   rdiovascu   ent 3   DOA   Other   Other   Other     of   28c. Inj. W   M   1   Other   Other   Other     street, factory, office   other   Other     ath occurred at the	26. Place ther. 4 Nu ury at ork?	iseas of Death	23e. Did tot  1  Ye  24a. Was a autops perform 1  Yes 2  1 (Check only on me 5  Reside 28d. Describe ho  28f. Location (St. City or Town	23d. Dai Mo  23d. Dai Mo  23d. Dai Mo  24b.  24b.  27 No  27 No  27 No  28 Solution  27 No  28 Solution  28 Solution  29 No  29 No  20 No  20 No  20 No  20 No  20 No  21 No  22 No  23 No  24 No  25 No  26 No  26 No  27 No  28 No  29 No  29 No  20	te of deliverenth tribute to the stribute to t	ry Day Year  e cause of death? ably 4 Munknown by findings available npletion of cause of 2 No	
Fundamental Comments of the fundamental director, page 2 st ould be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  Part II. Other	Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1   Live birt 4   Pregnar 9   Unknow ns contributing to dear Duind Infect Arterios Enfection Hospital: 1   Ming ation out be ned 28e. Place of building	as a consequence of):	ent 3 DOA of 28c. Ini M 1[ street, factory, office ath occurred at the investigation, in my	26. Place ther. 4 Nu ury at ork?	iseas of Death	23e. Did tot  1  Ye  24a. Was a autops perform 1  Yes 2  1 (Check only on me 5  Reside 28d. Describe house 28d. Describe house 28d. Location (St. City or Town and due to the caed at the time, did	23d. Dai Mo  23d. Dai Mo  Dacco use cont  as 2 No  n 24b.  Yell No  reef and Numb  reef and Numb  reef and place,	te of deliverenth  tribute to th	ry Day Year  e cause of death? ably 4 XUnknown  by findings available of cause of cause of cause of cause of the cause of the cause of the cause of the cause(s)	
The present of streaming and produce the produce of	edical Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birt. 4 Pregnar 9 Unknowns contributing to deal 2 Date of (Month, ation of be ned 28e. Place of building 2 Physician: To the bas and manne	as a consequence of):  as a consequence of):  as a consequence of):  as a consequence of):  me of pregnancy  n 2 Fetal death  at at time of death  the but not resulting in the  clerotic Ca  tatient 2 ER/Outpat  Injury  Day Year)  Injury - At home, farm,  etc. (Specify)  est of my knowledge, delease of examination and/or related.	ent 3 DOA of 28c. Inj. W M 1[ street, factory, office ath occurred at the investigation. in my	26. Place ther: 4 Nu ury at ork? Yes 2 let time, date an opinion, dea	iseas of Death irsing Hor	23e. Did tot  1  Ye  24a. Was a autops perform 1  Yes 2  1  (Check only on me 5  Reside 28d. Describe hor city or Town and due to the caed at the time, did	23d. Dai Mo  23d. Dai Mo  23d. Dai Mo  24b. 1  24b. 1  24b. 1  24b. 1  24b. 1  24b. 1  24c. 1  24c. 1  24d. 1	te of deliverenth  tribute to th  \$\frac{3}{\text{Proba}}\$  Were autoprior to condeath?  \$\frac{1}{\text{Q}}\$  Yes  The (Specify red)  The probability of the second of th	ry Day Year  e cause of death? ably 4 MUnknown  by findings available poletion of cause of 2 No  l Route Number, ated. the cause(s)  Day, Year)	
Fundamental Comments of the fundamental director, page 2 st ould be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birt. 4 Pregnar 9 Unknowns contributing to deal 2 Date of (Month, ation of be ned 28e. Place of building 2 Physician: To the bas and manne	as a consequence of):	ent 3 DOA of 28c. Inj. W M 1[ street, factory, office ath occurred at the investigation. in my	26. Place ther: 4 Nu ury at ork? Yes 2 let time, date an opinion, dea	iseas of Death irsing Hor	23e. Did tot  1  Ye  24a. Was a autops perform 1  Yes 2  1  (Check only on me 5  Reside 28d. Describe hor city or Town and due to the caed at the time, did	23d. Dai Mo  23d. Dai Mo  23d. Dai Mo  24b. 1  24b. 1  24b. 1  24b. 1  24b. 1  24b. 1  24c. 1  24c. 1  24d. 1	te of deliverenth  tribute to th  \$\frac{3}{\text{Proba}}\$  Were autoprior to condeath?  \$\frac{1}{\text{Q}}\$  Yes  The (Specify red)  The probability of the second of th	ry Day Year  e cause of death? ably 4 MUnknown  by findings available poletion of cause of 2 No  l Route Number, ated. the cause(s)  Day, Year)	

			For 1 - State Registrar	ouse			nd / Depa		f Health	and N	Mental Hy	giene	005	28179	
			Registrar  1. Decedent's Name (First, A	fiddle, La	st)			lineate	JI Deal		2. Date of Dea		000	3. Time of Death	
	Physici				h Kindle	е					Month Aug	$20^{Day}$	2005	2:35 A <sup>M</sup>	
}	/Medic Examin		4a. Facility Name (If not insti	ution, giv	e street and num	ber)		4b. City, Tov	n, or Location	on of Death		4c. Cc	ounty of Death		
			13714 Pop1a	ar Gr					erstov				ashing		
	Funeral		5. Social Security Number	6. 5	6ex 7 I□M 25☑F		last birthday) Yrs.	If Under 1 Y Months Da	ear If Und ays Hour	der 24 Hrs. s Min.	8. Date of Birt (Month, Day	h y, Year)	9. Birth	place (State or Foreign ntry)	
	Director		214-32-4907 Usual Residence of Deceder		71		,,,				Jul 19	1936		)	
	yland how		10a. State 10b. Co			10c. C	ity, Town or Lo				·			10d. Inside City Limits	
	Ba-f	cto	MD W	ashi	ngton		Hagers	town						1 ☐ Yes 2 X No	
	with th	Dire	10e. Street and Number	- C	D.J			10f. Zip Co	16 2 <b>1</b> 742			10g. Citize	n of What Cou USA	ntry?	
	eath 18 234	erai	13714 Pop1a	GIC	12. Was Deced	dent Ever in L	J.S. 13.			Origin? (Sc	pecify Yes or No-	. 14.	. Race - Ameri	can Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "nature!, or Items 23a or 28a-f ehow empty injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 3 Widowed 4 Divo		Armed Ford 1 Tyes 2 If Yes, Give Year or Dai	ces? 2⊠No i	1	If Yes, specify of 1 ☐ Yes 2 🛛			pecify Yes or No- p Rican, etc.)	1	Black, White, pecify: Whi	etc.	
2-0	72 hor	ted		edent's E	ducation ade completed)		16a. Dece	dent's Usual O	ccupation	ost of work	cina	16b. Kind	of Business/In	dustry	
Maryland 21215-0036	ithin 7	Completed	Elementary/Secondary (0-		College (1-	4or 5+)		kind of work d DO NOT use re S drive			9	d of e	ducation		
72	iled w Hygiei ther tl	S	17. Father's Name (First, Mic	idle. Last	)		Du	3 dilve		other's Nam	ne (First, Middle,				
and	ld be i ental l ked o	To Be	Edward Kuh								Greene		,		
ary	shou and M a mar umat		19a. Informant's Name/Rela	tionship (	Туре, Print)		19b. Maili	ng Address (St	reet and Nur	nber or Rui	ral Route Numbe	r, City or T	own, State, Zip	Code)	
	and 2		Simon Andr	ew K	indle	,					d. Hager		•		
Baltimore,	Pages 1 nent of He ent: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema	tion 3 [	Removal from S	late		nsition (Name of matory or other		1	Date		tion - City or To ington		
ţ	t. Pag rtment rtent:		'4 □Donation 5 □Oth			Ri	inggold	Cemete	ery	Aug	24 2005			MD. Home, Inc.	
Ba	Deparenti Impo eny Ir		21. Signature of Funeral Ser	Q.	1. 1. 1. 1.						ynesbore			Home, Inc.	
			23a. Part1. Enter the diseas	e, or com	plications that ca	used the dea					<del></del>	·	200	Approximate Interval Between	
E	Physician		shock, or heart failure. Immediate Cause (Final disease or condition	List only	one cause on ea		100	Car						Onset and Death	
	/Medical Examiner		resulting in death)	-	a Due to (o	or as a conse		(an	Cer					9 month,	
			Sequentially list conditions,	- 1	b										
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Secasa Secasa)	~	Due to (d	or as a conse	quence or):								
V	ate be executed hysicien end he burial-transit	Exan	that initiated events resulting in death) Last		c. Due to (c	r as a conse	quence of):								
760,	ysicie	cail		l	_ d										
68	leath certificat attending phy I for use as th	Medi	IF FEMALE:												
Вох	death certifica e attending ph d for use as th	ian/	23b. Was decedent pregnar in the past 12 months?		1 Live bir	outcome of pregnancy a birth 2 □ Fetal death 3 □ Ectopic pregnancy gnant at time of death 5 □ Other (specify)						230	23d. Date of delivery  Month Day Year		
0	0 0 0	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	.05	9 Unknow		oeatn 5t	Other (specify	//			10			
<u>a</u>	The law requires that the ste has been signed by the bage 2 should be detache	by Ph	Part II. Other significant co	nditions	contributing to dea	ath but not re	sulting in the u	nderlying caus	e given in Pa	ırt I.	23e. Did to	bacco use	contribute to t	he cause of death?	
rds,	w requires been sign should be										1 🗆 Y	es 2 🗹	√o 3 □ Prot	oably 4 Unknown	
Record	e law requ hes been ge 2 shoul	piet									24a. Was		24b. Were auto	psy findings available mpletion of cause of	
H		Completed									perfor 1 ☐ Yes	rmed?	death?	2 No	
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to me examiner?	dical	Hospital:						th (Check only o				
of		.: To	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 □ In		ER/Outpatie			Nursing Ho	ome 5 Aesid			(y)	
Ion	Attending Phir death.  • ctor: After thi by the funeral	ation	27. Manner of Death 28a. Date of Injury 1 ☑Natural 5 ☐ Pending 28b. Time of logic l												
Division	or Attendiated of the Attendiate	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Loc							ocation (Street and Number or Rural Route Number, ity or Town, State)					
Ö	To the Hospitel or Atta within 24 hours after de To the Funerel Directo completely filled in by tt	Cer						16							
	Hospitel 24 hours Funerel tely filled	dicai	29a. Certifier 1 Cer (Check only 2 Med	tifying Pl lical Exa	hysician: To the t miner: On the bas and manne	sis of examin	owledge, deal ation and/or in	h occurred at the vestigation, in a	ne time, date my opinion, d	and place, death occur	and due to the cred at the time,	cause(s) an date and pla	id manner as s ace, and due to	tated. o the cause(s)	
	To the within 2 To the comple	Med	29b. Signature and title of ce	ertifier	and mann			29c. Lie	cense numb	er		29d. Date s	signed (Month,	Day, Year)	
	- × - ō		> Mich	rel e	2. Mu	houn	L M	0	041	166-		E	.22.	05	
			30. Name and address of pe	rson who	completed cause	of death (Ite	m 23a) (Type,		1948.				. 1	when MO	
	10		Michae	1	J. Mc	orno	ick	11110	Me	dice	1 (cm	100	lose	when MO	
	Sta Registi		31. Date filed (Month, Day, AUG 2	g 2n	105 32 Re	gistrar's Sign	ature								
DH	IMH 17 Rev 1/2	à		0 20	UJ DE	We d	F So	W							
U	17 1169 1/2	501					ORIGINA	AL							

			1 - For State Registrar	State of Ma	aryland /		artment of H				iene g. N2	005	2818	30
	Physici	an	1. Decedent's Name (First, Middle, Last,	)					12	ate of Deat		Year	3. Time of De	
	/Medic		NELLIE G.  4a. Facility Name (If not institution, give	KEMP			4b. City, Town, or	r Location o		gust	8 07	nty of Death	8:00 A	
ı	Examin	er	Doctors Commun		oi+∋1		Lanham		or Death	•			Georges	_
	Funeral		5. Social Security Number 6. Sec	7. Age	o (In yrs. last b	irthday)	If Under 1 Year	If Under		ate of Birth		9. Birthi	place (State or Fo	
	Director		579-28-5918	]M 2⊠F	91	Yrs.	Months Days	Hours		Month, Day, $\mathbf{n} \cdot 1$	, 19	14 S	C	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City L	Imite
	Manyl f sho	20	DC		Wash:								1 <b>∑</b> Yes 2 [	
	288.	Director	10e. Street and Number		Nasii.	1119	10f. Zip Code		·	11	0a. Citizen	of What Cou	ntry?	
	h with	i Di	1726 Massachuse	etts Ave	., SE		2000	) 3				ed St	•	
	death	Funerai		12. Was Decedent E Armed Forces?		13.	Was Decedent of H		gin? (Specify		14. F	lace - Americ	can Indian,	
õ	or Ita		1 Never Married 2 Married	1 Yes 2 XN	lo		1 ⊡Yes 2 ⊠XNo	Specify:	i, rueito nicar	1, etc.)	Spe	Black, White,	etc.	
9500-91212	be filed within 72 hours after death with the Maryland ital thygiene. In the matural, or Itams 23a or 28a-f show ovent, I've Medical Erai, and must be mailified at event, I've Medical Erai, and must be mailified at	ed by	3 ☑Widowed 4 □ Divorced	Year or Dates:	1 40							Bla	-	
Ċ	in 72	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		(Give	tent's Usual Occupa kind of work done o DO NOT use retired	during most	t of working		16b. Kind <i>o</i> f	f Business/In	dustry	
7 7	with giene.	шо	Elementary/Secondary (0-12)	College (1-4or 5	+)		intenanc	•			CIA			
	be filed ital Hygi id other event, I	Be C	17. Father's Name (First, Middle, Last)						er's Name (Firs	st, Middle, A		ıame)		
yland		To	Clifton Blair					Sar	ah C	hinn				
Mar	0 4 5 5		19a. Informant's Name/Relationship (Ty		19	b. Mailir	ng Address <i>(Street a</i> B Capta <b>i</b>	and Numbe	er or Rural Rou	ite Number,	City or Tow	vn, State, Zip	Code)	
	is 1 and of Health Item 27 other tri		Helen Kemp/daug	hter	20h Place	Ippe	r Mar1h sition (Name of natory or other plac	oro,	Mary	land	20.7			
galtimore,	ages nt of h		1 ☑ Burial 2 ☐ Cremation 3 ☐ R		cemet	ery, crer	natory or other plac	(8)	2/16/0	_		n - City or To		
	permit. Pages Department of I Important: If Its any injury or or		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		наrmo		Mem . Pa					over,		
n n	Dep lmp any		Manua 18	MITTEL	Ma		910 Silv		_					
ı			23a. Part1 Enter the disease, or compli	ications that caused	the death. Do	not ent	er the mode of dying	g, such as	cardiac or res	piratory arre	SUITI est,	land,	Approximate	
	Pnysician :		shook, or heart failure. List only or Immediate Cause (Final disease or condition	1e cause on each lin		301	ORESPI	RAT	00 V	2.0	0.50=		Interval Between Onset and Deat	n ih
	/Medical		resulting in death)	a Due to (or as a			0100 31 1	12451	oky	1414	KEST	-		
	Examiner		Sequentially list conditions.	D			STIVE	146	ART	FAIL	URG	=		
	art sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	of):								
•	and al-tran	хап	that initiated events resulting in death) Last	Due to (or as a	consequence	of):								
2/60	cate be executed physician and the burial-transit	dical E	L.	4	,	,						4		
200		- w												
X Q Q	<ul> <li>requires that the death certifi</li> <li>been signed by the attending</li> <li>should be detached for use as</li> </ul>	Physician/M	230. Was decedent pregnant	3c. If yes, outcome o	of pregnancy	h 3[	Ectopic pregnancy				23d. [	Date of delive	эгу	
	e dea he att	sicle	2.50. Was described pregnant in the past 12 months?  1 ☐ Yes 2 ☐ Wo 9 ☐ Unknown									Month Day Year		
л Э	d by t	Phy	9 Unknown						District Control of the Control of t					
gs,	requires that the een signed by th hould be detache	l by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hisknown				
Ö	v requ	etec					10							
Hecords,	8 S N	e Completed		IBBETI	C 2 M	رت د	C 1705		2	4a. Was an autopsy perform	1 240 / led?	prior to cor death?	psy findings avail npletion of cause	able of
VII			25. Was case referred to medical					OC Disease		☐ Yes 2	<b>⊠</b> No	1 🗆 Yes	2 X No	
	> 0 0	0 0	examiner?	lospital:	nt 2□ER/O	utpatien	t 3 DOA Othe	200	of Death (Che			ther (Specifi	4)	
10 [	ding Phys h. After this funeral di	n: T												
UNISION	endir eath. or: Af	catic	Natural 5 Pending 2 Accident investigation	(	,	,u.y		res 2□N	No					
Ĕ	al or Attending P s after death. I Diractor: After d in by the funera	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.	ry - At home, f . (Specify)	arm, stre	eet, factory, office			ocation (Str City or Town,		nber or Rura	l Route Number,	
_	pltal or Attenous after deat ours after deat eral Diractor: filled in by the	O	29a. Certifier 1 Certifying Phys						1					
	수 교 수	edical	(Check only 2 Medical Examir one)	sician: To the best oner: On the basis of and manner states	examination a	e, death nd/or inv	occurred at the tim restigation, in my op	e, date and pinion, deat	d place, and di th occurred at	ue to the car the time, da	use(s) and r te and place	manner as st e, and due to	ated. the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. License	number		29	d. Date sign	ned (Month, I	Day, Year)	
			· Va	un les.	_ ^	11	D	00 <	5829	0	81	9/05		
2	(5)		30. Name and address of person who co	mpleted cause of de	ath (Item 23a)	(Type,			(			-		
/			SURESHKUMAR				QUEEN	USB U1	RY R	D. 13.	YATTS	SVILLI	EMDZ	078)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature									
	region	-11	AUG 1 5 2005	La serie	45	1100								

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 2005 August 12. Phoebe Lee Kirby 11:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pineview Nursing Home Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year)

October 17, 1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2√₹ 89 Yrs. 415-24-7656 Tennessee Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show other traumatic event, if a Medical Examiner rout be notified at Maryland Prince George's Oxon Hill 1 Yes XXXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important; if Itam 27 is marked other than "natural", or Items 23a any hijury or other traumatic event; It e Mudical Examiliner manal. 14. Race - American Indian, Black, White, etc. Completed by Funeral 5107 Wheeler Road 20745 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes <del>2 ☐ No</del> Specify: 3 ₩idowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4 Homemaker At home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ollie Rice Henry Hines ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert William Hines / Son 5107 Wheeler Road Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ŽŽ Cremation 3 ☐ Removal from State \_08/13/2005 Edgewater. Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 21. Signatur / Funeral Service Licensee 23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIOPULMONARY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner END STAGE ALZHEIMERS DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit CANCER OF COLON and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown hypertension Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? urosepsis 2 No 1 🗌 Yes 2 TNo 1 TYAS 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08-19-05 D51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 422 Oakton, Virginia Bahram Pishdad MD 31. Date filed (Month, Day, Year) State AUG 1 5 2005 Registrar

			State of Maryland / Department of Health an Certificate of Death		Reg. No.		28182
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> ELEANOR E. KINARD	2. Date of I Month August	Day	Year 2005	3. Time of Death
4	· /Medic Examir			n, or Location of De			12:33am
Ĺ.			3609 65th Avenue Hyatts			nce Geo	
Ĺ	Funeral Director		5. Social Security Number  116-18-4705  0. Sex 1	Min. 8. Date of 8 (Month, 1 May 1	Sirth Day, Year) , 1920	9. Birthplac Country, South	e (State or Foreign Carolina
	ylend		10a. State 10b. County 10c. City, Town or Location			10d.	Inside City Limits
	Ba-f sl	ctor	Maryland Prince George's Hyattsville				1X Yes 2 □ No
	with th	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of		?
	Jeath Jeath	eral	3609 65th Avenue 20784  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or N	US 10- 14. Rad	e - American	Indian,
020	urs after of all, or item	by Fur	Armed Forces?  1 □ Never Married 2 Married  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  Armed Forces?  1 □ Yes 2 Mo Specify:  1 □ Yes 2 Mo Specify:	Puerto Rican, etc.)		ck, White, etc v: $B1$ ac	
Maryland 21215-0020	d 2 should be filed within 72 hours after death with the Merylend in end Mental Hyglene. It is marked other than "natural", or itema 23a or 28a-f show traumatic event, it a Medical Evairing must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	f working	16b. Kind of B		try
7	filed v Hygie other t	ပ္	12 HouseWife/Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Midd		ivate_	
<u> </u>	Aental Aental rkad c	To Be	Elbert Beasley Mary	Fergus	on		
/ar√	2 sho end N is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Street and S			State, Zip Co	de)
	1 an Heel Heel sm 2		Claudette A. Beamer - Daughter 1432 Albert Drive M  20a. Method of Disposition  20b. Place of Disposition (Name of commetter), crematory or other place)	litchellv:	ille, MD	2072]	
ō E	Pages nent of nt: If its iry or o		1 (X) Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  **Coemetery, Crematory or other place)*  **Maryland National Cemeters**	8-18-05		rel, M	
Baitimore,	permit. Pages Depertment of Important: If it any injury or o	Ì	21 Sheature of Funeral Service Licensee 22 Name and Address of Facility	Jordan Fi			
n	90 E 29		4001 Benning Road	d Washin	gton, DC		
	<b>6</b> 1		23a. Bart1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	rdiac or respiratory	arrest,	Int	proximate erval Between aset and Death
A Street	Physician /Medical		Immediate Cause (Final disease or condition Multiple Myeloma				Months
	Examiner		disease or condition a. <u>Multiple Myeloma</u> resulting in death)  Due to (or as a consequence of):				
	nsit	mlne	<b>b</b> .			i I	
ĵ	an and	Еха	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.				
<b>08/00</b> ,	requires that the death certificate be executed een signed by the attending physician and hould be deteched for use as the buriel-trensit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
מ א	certific rding p	_	d				
. BOX	death e atter	siclar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Die	i tobacco use co	ntribute to the	causa of death?
л Э	v requires that the death certiff been signed by the attending should be deteched for use as	Physician/N			Yes 2∰ No		ly 4 □ Unknown
ds,	signe signe	d by		24a Wa	s an autopsy	24b Were	autopsy findings
	- D 0	Completed		per	formed?	availat	ole prior to etion of cause
ב ב	The la ete has page 2	EO		1□	Yes 2 XNo		es 2 No
<u> </u>	cian: sertifica ector,	Be	examiner?	Death (Check only	one)		
ō	Attending Physician: The law ir death. ector: After this certificete has by the funeral director, page 2	5 5	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ng Home 5 🕅 Res	idence 6 Doth how injury occur		
	ttending death. ctor: Afte y the fun	ation	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Numb own, State)	er or Rural Ro	oute Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death of and manner stated.	lace, and due to the occurred at the time	cause(s) and ma , date and place,	inner as stated and due to the	d. cause(s)
	Veith Co	Ž	29b. Signature and title of certifier 29c. License number		29d. Date signe		
	(6)	-	D18219		August	12,	2005
2	0		30. Name and addrest of person who completed cause of death (Item 23a) (Type, Print)  Stephen Staal, MD 1221 Mercantile Road, Largo, MD 2	20774			
	Sta	,,,	31. Date filed (Month, Day, Year) 82. Registrar's Signature			<del></del>	
	Registr	11	AUG 1 5 2005 Keeke & State				

DHMH 16 Rev 6/95

				For State Registrar	State	of Marylan		artment of H		i Mental Hy	giene Reg. N2 0	05	28183
		• Physici	an	1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month	Day	Year	3. Time of Death
		/Medic	al	WILLIAM LOUIS  4a. Facility Name (If not institution		imber)		4b. City, Town, or	r Location of De	Augus		2005 nty of Death	8:15 a M
		Examin	er	Joseph Richey	-	in boly		Baltimor		auı		ltimor	
		Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 H		rth av. Year)	9. Birth	place (State or Foreign
		Director		220-26-4907 Usual Residence of Decedent	1 <b>∑</b> M 2□ F	90	Yrs.	morning Days		July 4	, 1915	Kans	
		land w		10a. State 10b. County		10c. Ci	y, Town or Lo	ocation					10d. Inside City Limits
		the Marylan 28a-f show	ctor	Maryland Princ	e George	s Co	11ege	Park					1 X Yes 2 □ No
		rs after death with the Maryle ', or Itama 23s or 28a-f shoi vartiner must be notified at	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen o		ntry?
		a 23e	eral	9605 49th Ave		cedent Ever in U	S 12	20740	ispanio Origin?	(Specify Vec or N	U.S.A	A. lace - Ameri	can Indian
		fter de r Itam inerr	Fun	11. Marital Status 1 ☐ Never Married 2 🕅 Mari	Armed F ried 1 ☐ Yes	orces? 2 🔯 No		Was Decedent of H If Yes, specify Cuba		erto Rican, etc.)	В	lack, White,	
	036	rel', or	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1□Yes 2XNo	Specify:		Spec	cify: Wh:	ite
	15-0	filed within 72 hours after death with the Maryland Hyglene. ther then "naturel", or Itama 23a or 28a-f show ther the Medical Evaruinet must be retilled a	Completed by Funeral Director		t's Education st grade completed	)	16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of v	vorking	16b. Kind of	Business/In	ndustry
	12	withir lene. then	omp	Elementary/Secondary (0-12)	College	(1-4or 5+)		yor/US Go			US Ge	eologi	.cal Services
	br		Be C	17. Father's Name (First, Middle,	Last)			, , , , , , ,		lame (First, Middle			
	ylaı	should be nd Mental marked c	To E	Joseph Krashoo						e Lauritz			
	Maryland 21215-0036	is 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relations				ng Address (Street					•
\		Health Health tem 27		Edith Krashoc  20a. Method of Disposition	- Spouse	20b. F		49th Ave sition (Name of matory or other place		Date Pa	20c. Location	-	
5	E E			1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5				oln Cemetei	ry 8/1	15/2005	Brent	wood,	Maryland
	Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Euneral Service	Licensee /			2. Name and Addres				-	
-	<u>m</u>	89 <b>2</b> 2		Valual to	Am)	11013						, Mar	yland 20781
-				23a. Fart1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.	-		g, such as card	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	(or as a consec		ance/					yks
		Examiner			I busin	(0) 43 4 0011360	derice ory.						•
	16	# Q	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	uence of):						
		and I-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c	(or as a consec	mence of):						
Ź	8760,	cate be executed physician and the burial-transit				(-	,						
14	687	tificate ig phy as the	hysician/Medical		- 4								
2	30X	The law requires that the death certific the has been signed by the attending plate has been signed by the attended for use as page 2 should be detached for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnation	I death 3	⊒Ectopic pregnancy			1	Date of delive	ery Day Year
$\sim$	O. B	at the dea by the at tached fo	ysici	1 Yes 2 No	4□Preg 9□Unki	nant at time of c nown	leath 5	Other (specify)				norm,	Day rear
\	σ.	that the	0	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use co	ontribute to t	he cause of death?
0	Records,	w requires that been signed b should be det	ed by							1 🗆	Yes 2□No	3 🗆 Prot	pably 4 Unknown
<u>ج</u>	oce	e law re has bee je 2 sho	ompleted							24a. Was		o. Were auto	opsy findings available
Krasho			Com								ormed? 2 Z No	death? 1 🗆 Yes	mpletion of cause of 2 No
X	Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital			oth all Don Oth	00	eath (Check only	,		Liana.
A	of	ding Phys	n: To	1 Yes 22 No 27. Manner of Death	1	Inpatient 2 of Injury oth, Day Year)	ER/Outpatier 28b. Time o	f 28c. Injun	y at	Home 5 ☐ Res 28d. Describe	how injury occ	Other (Specificurred	(V) Mospies
a	ion		atio		gation	ntn, Day rear)	Injury	M 1 🗆	K? Yes 2 □ No				
=	Division	I or Attendi after death. Director: A in by the fo	ertification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Plac	e of Injury - At h ding, etc. (Speci	ome, farm, sti fy)	reet, factory, office		28f. Location City or To	(Street and Nui wn, State)	nber or Rura	al Route Number,
$\geq$		To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	O	29a. Certifier 1 Certifyi	ng Physician: To th	a hast of my kn	owledge deat	h occurred at the tin	ne date and pla	use, and due to the	cause(s) and	manner as s	tated
-		To the Hospite within 24 hours To the Funerel completely filled	edicai	(Check only 2 Medical one)	Exeminer: On the	basis of examina nner stated.	ation and/or in	vestigation, in my o	pinion, death or	curred at the time.	, date and place	a, and due to	o the cause(s)
		To the within 2 To the complet	Me	29b. Signature and title of certifie	er			29c. Licens	1		29d. Date sign		1
		(A)		2180M	)			92	4170		Hugus	t 11,	2005
0	2	(5)		E. TSO MD R	1	pice 83 Registrar's Sign	8 NE	entan St	Balt	imera t	10 2	1201	
	Pie	Sta Regist		31. Date filed (Month, Day, Year AUG 1 5	2005	Registrar's Sign	for	who when					

State of Maryland / Department of Health and Mental Hygiene 200528184 For State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) lewis Month **Physician** 22:51P<sup>M</sup> 8, 2005 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Clinton

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Southern Maryland Hospital 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 5, Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 ☐ F 74 Yrs 1931 Director 243-42-3474 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County worle ral', or itams 23a or 28a-f ehov Exeminer must be notified at 1 Yes 2 No Md. P.G. Suitland Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 4800 Huron Avenue 20746 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iter 1 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Mac Elementary/Secondary (0-12) College (1-4or 5+) 12 Psychiatric Technician St. Elizabeth Hosp. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be f Health and Menta Carl Lewis Sr. Julia Moore 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Huron Avenue
Sultiland, Maryland

20b. Place of Disposition (Name of cemetery, crematory or other place) Maceon Lewis/wife 20746 20a. Method of Disposition ō <u>=</u> 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Resurrection Cem. 8/13/05 Clinton, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardio Varala hexoscleratic Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Prumoni. w Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physiclan/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probably 4 🗗 Unknown 2 🗆 No 1 ☐ Yes Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? has page 2 certificate 1 ☐ Yes 2**[** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ZÑNo ဥ 2 Z ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 ■ Natural 2 □ Accident 5 Pending 1 □ Yes 2 □ No death. investigation Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral C Hospital 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D45365 11701 livingston Nd #101, ft washington 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sida Rous, M.D Michael 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2005 Registrar

		•	1 - State Registrar	State of Ma	arylan	_	artment of F		d Mental		71115	28186
			Decedent's Name (First, Middle, Last)				tinoato oi	Death	2. Date	Reg. No	0	3. Time of Death
	Physici		PATRICIA		o.		MURPH	Υ	Aug	n Da		
	/Medic Examin		4a. Facility Name (If not institution, give s		•		4b. City, Town, o				c. County of Dear	
			3116 Fallston	Road				Fallst	on		Har	ford
	Funeral		5. Social Security Number 6. Sex	7. Age		last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of	of Birth h, Day, Year		hplace (State or Foreign
	Director		Usual Residence of Decedent	IM ZUALF	68	Yrs.			8/7	/193		aryland
	land		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary -f sh	tō	MD. Harfo	rd			Fa	llstor	1			1 ☐ Yes 2 X No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?
	th wit	ai D	3116 Fallst	on Road				21047	7	Uı	nited S	States
۳	ems ems	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.	S. 13. \	Was Decedent of H	ispanic Origin?	(Specify Yes	or No-	14. Race - Ame Black, Whit	
36	s afte	Y F.	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 📉 N If Yes, Give	10		I ☐ Yes 2 No	Specify:			0	<i>h</i> ite
21215-0036	72 hours after death with the Maryland neturel', or items 23s or 28s-f show dical Evandras musi be nutified at	Completed by	15. Decedent's Edu	Year or Dates:		16a Decer	lent's Usual Occup	ation		16h k	Cind of Business	
15	n "ne	plet	(Specify only highest grade	completed)		(Give life.	kind of work done DO NOT use retired	during most of	working	100.1	and or Dasiness	industry
212	filed within Hygiene. sther then "	E O	9	College (1-4or 5	+)	Bene	fits Co	-ordir	nator	1	Labor I	Jnion
	ba file ital Hy id oth event	Be (	17. Father's Name (First, Middle, Last)					18. Mother's I	Name (First, M	iddle, Maidei	n Sumame)	
yla	should bend manked imarked	၉	Daniel		F	laher			Marie			helen
Maryland	O G G G		19a. Informant's Name/Relationship (Ty)			1	g Address (Street					
	of Health of Health I Item 27 I		Leroy Kucharczy  20a. Method of Disposition	k/ Son	20b. P		Box 5 sition (Name of	19 1	Date		lary Lar .ocation - City or	nd 21047
nor	Pagas nent of int: If it iry or o		1  Burial 2  Cremation 3  R  4  Donation 5  Other (Specify)	emoval from State	C	emetery, cren	natory or other plac					
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Servil Licens	/ ()	TIT. T.S		. Name and Addre					Iills, Md.
ñ	Depa Impo any ir		11 Mereld	237 /1/	to		E.G. Ku		Son F	unera	al Home	Maryland
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused	the death						11011	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	NOW	-50	all (	ell Lien	9 CAN				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):	Let William	1	Cara			7
П	Lammer	_	Sequentially list conditions,				(	/				
V	ted nsit	nine	at any Isacing to immodiate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consagn	ieuca citi:						
<u> </u>	axecu n and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):						
8760,	cate be axecuted physician and the burial-transit	dicail										
9		ledi										
Вох	that the death certifi ed by the attending detachad for use as	by Physician/Me	230. was decedent pregnant	3c. If yes, outcome 1 Live birth			Ectopic pregnancy			1	23d. Date of del	,
O. E		sici	in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	4☐ Pregnant at 9☐ Unknown			Other (specify)				Month	Day Year
<u>G</u>	requires that the een signed by th hould be detache	Phy	Part II. Other significant conditions con	tributing to death hi	it not resi	dting in the u	rderlying cause giv	en in Part I	230	Did tobacco	use contribute to	the cause of death?
Vital Records,	se us	d by	MACROSTOBULIANO				ioonying oddoo giv	ott iit i dit i.	255.	1/		obably 4 Unknown
COL	> 10 0	Completed			-				242	Was an	24h Wara au	topsy findings available
Re	The law cate has b	дшс							-   _	autopsy performed?	prior to death?	completion of cause of
tal	icien: Th certificate rector, pag	Be C	25. Was case referred to medical					26 Place of [	1 ☐ Y Death (Check o		1 LJ Yes	2 □ No
	dis X	ToB	examiner? 1 ☐ Yes 2 No	ospital: 1 🗌 Inpatie	nt 2 🗆	ER/Outpatien	t 3 DOA Oth	ar	g Home 5	A	6 ☐Other (Spec	city)
n of	ding Ph th. After thi funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		28b. Time of Injury	28c. Injur Wor	at k?	28d. Desc	ribe how inju	iry occurred	
sio	Attending or death.  ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No				
Division	Dir fte	Certification:	4 Homicide determined	28e. Place of Inju building, etc	iry - At ho :. <i>(Specif</i> y	me, farm, str	eet, factory, office		28f. Locat City o	ion (Street a or Town, Stat	nd Number or Ru e)	ral Route Number,
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier Certifying Phys	ician: To the best of	of my know	wledge, death	occurred at the tir	ne, date and nia	ace, and due to	the cause/s	and manner as	stated.
	n 24 h	edicai	(Check only 2 Medical Examinate)	er: On the basis of and manner sta	examinat	ion and/or inv	restigation, in my o	pinion, death of	ccurred at the t	ime, date an	d place, and due	to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier	1 1	1		29c. Licens	e number		29d. Da	ite signed (Monti	n, Day, Year)
)			Muhuelle	unker	ch		13	355/		Au	9 22,	2005
	6		30. Name and address of person who co	mpleted cause of de	eath (Item	23a) (Type,	Print)	42.01	Q1.	0	2	~ 7
61	Sta	to	31. Date filed (Month, Day, Year)	32. <b>Pe</b> gistra	n's Signal	ture With	KO H	3/4/	URIT!	MAKE	2 11	154
	Registr		AUG 2 9 200	100		1. 60	ade					
			1144 0 0 001				-1765.63					

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** PHYLLIS J. MARSH AUGUST 14 2005 4:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 29776 TRACEY'S WAY EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. OCIT 8, 1939 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 21XF NEW YORK 65 130-30-9740 Yrs. Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23s or 28e-f show traumatic event, the Medical Exp. item matter rotational 1X Yes 2 No Completed by Funeral Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29776 TRACEY'S WAY 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. 12 REAL ESTATE 0 SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BORIS GOLDSTEIN MARGARET BURNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID L. MARSH/HUSBAND 29776 TRACEY'S WAY, EASTON, MARYLAND 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of Hi
Important: If iter
any injury or oth 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) UNION CEMETERY 8/19/2005 EASTON, CT. 22. Name and Address of Facility
FELLOWS, HELFELDELINE STON, MD FUNE AL
200 S. HARRISON ST EASTON, MD FUNE AL 21. Signature of Funeral Service Licensee HOME PA JOHN Z. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast Concer Physician lears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of): physician at s the burial-t P.O. Box 68760. Physician/Medical as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 1 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à End Stage Renal Disease 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy 1☐Yes 25 No certificate 1 Yes 25 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 21/2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5X Residence 6 | Other (Specify) this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 12 Natural 2 Accident 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8/15/05 20057067 oshel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTON MP 21601 Dr. LANE DUTCHMANS 2005 32. Regular's Signature Registrar

			1 - For State Registrar	State of Maryland		artment of H			2005	28188
H	Physicia	an	Decedent's Name (First, Middle, Last)	Manusin				2. Date of Death Month	Day Yea	3. Time of Death
	/Medic Examin		Ronald Haye  4a. Fecility Name (If not institution, give si		g	4b. City, Town, or	Location of Death	August	8, 2005 4c. County of De	eath
	Funeral Director		1115 Davis Lane 5. Social Security Number 216-64-9392  Usual Residence of Decedent	7. Age ( <i>In yrs. l</i> as	st birthday) Yrs.		alsburg If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y April 24	Carol (ear) 9. E ,1953 V	ine linthplace (State or Foreign Country) irginia
	yland how		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	he Ma 28a-1 s ouiffed	ecto	Maryland Caroline	F.	edera	1sburg				112 Yes 2 □ No
	3a or 3	Funeral Directo	1115 Davis Lane			10f. Zip Code 21632		100	. Citizen of What USA	Country?
	r deat	ner		<ol><li>Was Decedent Ever in U.S. Armed Forces?</li></ol>		Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		nerican Indian,
020	parmit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If than 271 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, I'tu Modicul Exam national to molified a once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 Ø No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	Black
2	n 72 ho "natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup- kind of work done of DO NOT use retired	during most of work	sing 16	b. Kind of Busines	
7 7	d withi giene. ar than	omo;	Elementary/Secondary (0-12)	College (1-4or 5+)		ng & Land			Robert &	Son Paving
	be file Ital Hy ad otha avant,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
AT YIE	should ind Men marka umatic	ဥ	James Roos  19a. Informant's Name/Relationship (Typ	sevelt Mouri		ng Address (Street		ane Myric al Route Number, (		, Zip Code)
-	and 2 ealth a n 27 ls		Floyd Peterson /		P.O.	Box 458,	Preston,	Maryland		
0	Pagas 1 nent of H int: If ital iry or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State cen	netery, crer	sition (Name of natory or other plac	ca)		c. Location - City	or Town, State
	parmit. P Departme Important any injury once.		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			town Cem 2. Name and Address	ss of Facility		Hurlock,	
<u> </u>	parmi Depa Impo any is		- Moulla	Kninger		Bennie S 516 S.Ma	mith Fundin Stree	eral Home t, Hurloc	k,Maryla	nd 21643
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused the death. e cause on each line.						Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce f):			ARCTIC		REVIE
	Lamme	e.	Sequentially list conditions, if any, leading to immediate	Due le (or as a conseque	SVE nce of):	CARDIT	VASCUL	ar Dis	698	CHRONK
	acuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							4
o,	sician a	ical Ex	resulting in death) cast	Due to (or as a conseque	nce of):					
00	rtificate ng phys as the		d.							1
.O. DOX	The law requires that the death carificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)	·		23d. Date of o	lelivery Day Year
cords, r	w requires that been signed b should be deta	by	Part II. Other significant conditions conditions.	ributing to death but not result	ing in the u	nderlying cause give	en in Part I.			to the cause of death?  Probably 4 Mulnknown
ם שבו		Completed				,		24a. Was an autopsy performe 1 ☐ Yes 2 €	d? prior t	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ysiciar is certif directo	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ EF	2/Outpatier	nt 3□ DOA Oth	00	th (Check only one) ome 5 Residence	ce 6 □Other (Sc	pacifu)
5	ng I fter iner	lon: T	27. Manner of Death 1 ® Natural 5 ☐ Pending		8b. Time o	f 28c. Injun World	y at k?	28d. Describe how		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attanding Physician: The la within 24 hours after death.  To the Funaral Director: After this certificete has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	M 1 []	Yes 2 □No	28f. Location (Stree City or Town,	et and Number or State)	Rural Route Number,
_	ospital hours a unaral i ly filled		29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knowl	edge, deat	h occurred at the tin	ne, date and place,	and due to the cau	se(s) and manner	as stated.
	thin 24 thin 24 tha Fi	Medical	29b. Signature and title of certifier	er: On the basis of examinatio and manner stated.	M. F	> _29c. License			. Date signed (Mo	
	F 3 F 8		· Christian /	Jensen,	1119	Die	4664	C	8/11/	2005
			30 Name and address of person who con	notered cause of death (Item, 2	3a) (Type	Print Dento	on MD	2167	9	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	гө	Acre-			1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year JOYCE BARTON MILES AUGUST 13 2005 9:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CORSICA HILLS NURSING HOME QUEEN ANNE'S CENTREVILLE
If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Days Hours Min. Months **Director** 221-18-4615 75 JAN. 3,1930 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 Yes 2 No Directo MARYLAND QUEEN ANNE'S WYE MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14141 OLD WYE MILLS ROAD 21679 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: If Yes, Give Year or Dates: Specify. 3 ¥ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 TELEPHONE OPERATOR COMMUNICATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 EMMETT A. BARTON SARA CANNON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 MILES LEHMANN (NEPHEW) 311 E. FRONT STREET MEDIA, PA 19063 20b. Place of Disposition (Name of cometery, crematory or other to OLD WYE PARISH CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it 1 Burial 2 Cremation 3 Removal from State <sup>¹</sup> 4 □Donation 5 □ Other (Specify) 8/20/2005 WYE MILLS, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. any ir 408 S. LIBERTY STREET CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIC mulh 48/0m /Medical Due to (or as a consequence of): Examiner stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed meestre Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Ulmonay IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 robably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an TENSION autopsy performed certificate 2 No 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ů 1 Inpatient 2 ER/Outpatient 3 DOA this neral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural 5 Pending Injury investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

05UU State STATISTICS AND STATES 
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

2540 CENTREVILLE ROAD, CENTREVILLE, MD 21617

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of l	lealth and M Death		giene Reg. No. 2005	28190
	۰		Decedent's Name (First, Middle, I	.ast)				2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Howard L. Ma	rkham.Jr.				August	Day Year	9:40P M
	Examin		4a. Facility Name (II not institution, g			4b. City, Town, o	r Location of Death	Nugus	4c. County of Death	
			10700 Prince	Charles I	Orive	La P	lata		Charles	S
	Funeral			Sex 7. Age	e (In yrs. last birthday	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Birth	nplace (State or Foreign
	Director		378-34-0660 Usual Residence of Decedent	70 W 201	67 Yrs.		De	cember	16,1937	ΜΊ
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Many First	ţō	MD Chai	:les	La	Plata				1 XYes 2 ☐ No
	r 28g	Director	10e. Street and Number	-		10f. Zip Code			10g. Citizen of What Cou	untry?
	23a o	ai D	10700 Prince	Charles I	Orive	20	646		USA	
	ems	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
36	ours after death with the Marylar ral', or items 23a or 28a-f show Examinat must be molified at	by Fu	1 Never Married 2 Married	1 May Yes 2 □ N If Yes, Give	lo	1 ☐ Yes 2 ☑ No	Specify:	r nour, otc.)		nite
Ö	프 크 및		3 Widowed 4 Divorced	Year or Dates:						
7	n 72	Completed	15. Decedent's (Specify only highest of	rade completed)	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired	during most of work	ing	16b. Kind of Business/I	ndustry
212	s withir iene. r than	E o	Elementary/Secondary (0-12)	College (1-4or 5	+)	ohics An			CTA	
b	e filed with al Hygiene. other than vent, the N	o l	17. Father's Name (First, Middle, La	st)	, GI a	JIIICS AII		e (First, Middle.	Maiden Sumame)	
Maryland 21215-0036	0 2 0	To B	Howard Leroy	Markham			Esthe	r Talle	eγ	
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship				and Number or Rur	al Route Number	r, City or Town, State, Z.	
	s 1 and 2 of Health a item 27 is other trai		Roseanne Marl	cham/Wife			e Charle	es Dr.	La Plata	MD 20646
ore	ges 1 and of Healt if item 2 or other		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3	□Removal from State		ematory or other place	(e)		20c. Location - City or 1	
Ë	Pag Iment tant:		`4 □ Donation 5 □ Other (Spec	cify)	Brinsfie	eld-Echo	ls 8/13,	/05 Cl	narlotte I	Hall,MD
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Lic	ensee ( ) ) N	100945	22. Name and Address AREHART	ss of Facility	FUNERA	AL HOME,P	A
	403 a a		23a. Part1. Enter the disease, or co	convis		P.O. BO	X 567,L	A PLATA	MD 20646	5
Щ			snock, or neart failure. List on	mplications that caused ly one cause on each lin	the death. Do not en	nter the mode of dyin	ig, such as cardiac i	or respiratory arr	rest,	Approximate Interval Between Onset and Death
1	Pnysician /Medical	ı	Immediate Cause (Final disease or condition resulting in death)	a		C	erc e	~ .		Onset and Death
	Examiner		1	Due to (or as	a consequence of):	0				
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć.	exec in and ial-tra	Еха	resulting in death) Last	Due to (or as	a consequence of):					
8760,	icate be executed physician and s the burial-transit	dicai		d						
9	ntifica ng ph as th	Jed	IF FEMALE:							
Вох	death certifica e attending ph ed for use as t	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		□Ectopic pregnancy	,		23d. Date of deliv	
О.	e dea the at red fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown		Other (specify)			Month	Day Year
<u>Ч</u>	that the de led by the a detached i	Phy						00 8:11		
JS,	es be	by	Part II. Other significant conditions	contributing to death be	at not resulting in the	underlying cause give	en in Part I.		bacco use contribute to es 2□No 3 <del>□P</del> ro	
Records	w requires been sign should be	ompleted						101	es 2 No 3 Pro	bably 4 Unknown
3ec	e la has	mp						24a. Was a autops perform	sy prior to co	opsy findings available ompletion of cause of
a	ian: The I rtificate ha stor, page	O	05.446						2⊟ Vo 1 ☐ Yes	2□ No
Vital	Se Se	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Hospital:		other actions Other	er:			
of		Η.,	27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		III 3 DOA	4 🗀 Nursing Ho		ence 6 Other (Spec	ify)
ion	to Agra	ation	1 Fatural 5 ☐ Pending investigat		Year) Injury	Worl	k? Yes 2 □No		, ,	
Division		ific	3 ☐ Suicide 6 ☐ Could not determine	a 28e. Place of Inju	iry - At home, farm, s	treet, factory, office		28f. Location (St	treet and Number or Rur	ral Route Number,
Ö	tal or A s after al Direction by	Certification:	4 - Houndo	building, etc	c. (Specify)			City or Town	n, State)	
	Hospital 4 hours a Funeral tely filled	edical (	29a. Certifier 1 Certifying 1 (Check only 2 Medical Ex	hysician: To the best of	of my knowledge, dea	th occurred at the tim	ne, date and place,	and due to the ca	ause(s) and manner as	stated.
	the the	ledi	57.07	and manner sta	ted.				late and place, and due	
	Vity Con	Σ	29b. Signature and title of certifier	Lilla	00	29c. License	e number	2	9d. Date signed (Month,	, Day, Year)
,			- Korik-	1 100	ULL	1)7	551	7	8/12/1	
1	R1281		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type	Print)		\^ ^.	0 1-	1116
(1)	Sta	10	31. Date filed (Month, Day, Year)	32 Palaistra	ar's Signature	Ce 1 6	Na	1013	0 7 0 (	570
A.C.	Registr		AUG 1 5	67	w & A	berke				

)5398			State of Marylan	d / Departn	ent of Health	and Ment	al Hygien	60 0 0 C	00101
	•	1 - For State Registrar Amend #7.& 100	Don't DCC or		cate of Deat		Reg. N	2000	28191
The same		1. Decedent's Name (First, Middle, Last)	. PEL FILEGO CL		34.0 0. 2 0	2. D	ate of Death		3. Time of Death
Physic		cesar de Jes	us Mayorga					ay Year .02005	0700 M
/Med Exami	_	4a. Facility Name (If not institution, give s	street and number)	4b.	City, Town, or Locatio			c. County of Death	
	ш	8001 New Hampshir			Hyattsvill			Prince G	
Funeral	- 1	5. Social Security Number 6. Sex		last birthday) If I Mo	Inder 1 Year If Und onths Days Hours	s Min. 8. D.	ate of Birth Month, Day, Yea an / 10 /	9. Birth	place (State or Foreign ntry)
Director		None Usual Residence of Decedent	<del>74</del> -	7 110.		J	all/ 10/	1909 Gua	atemala
yland		10a. State 10b. County	10c. Cit	y, Town or Locatio	n			1	10d. Inside City Limits
Mar.	to	Md Prince Ge	eorge's H	rattsdi:	le H	[yattsvi	lle		1 ZYes 2 □ No
th the	lrec	10e. Street and Number		10	of, Zip Code			itizen of What Cour	•
be filed within 72 hours after death with the Maryland tal Hygiene. Individual then "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Funeral Director	8101 New Hamps			20783			uatemala	
er des	une		12. Was Decedent Ever in U Armed Forces?	.S. 13. Was	Decedent of Hispanic ( , specify Cuban, Mexic	Origin? (Specify Y can, Puerto Rican	res or No- n, etc.)	<ol> <li>Race - Americ</li> <li>Black, White,</li> </ol>	
s afte	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Giver Year or Dates:	1 💍	'es 2□ No Speci	<sup>ity:</sup> Guater	mala	Specify:	ispanic
tura stura	edt	15. Decedent's Edu		16a. Decedent's	Usual Occupation			Kind of Business/in	
7 2 2 2	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind life. DO N	of work done during m OT use retired)	nost of working			
d in 15-0050 ad within 72 hours aft giene. er then "natural", or the Medical Exami	Completed	3rd.		Cons	ruction		A	bel's Co	oncrete
al Hygid al Other	Be (	17. Father's Name (First, Middle, Last)			18. Mo	ther's Name (Firs	t, Middle, Maide	n Sumame)	
d 2 should be filed within the and Mental Hygiene. If is marked other then traumatic event, the M	7	Flavio Jose Ma				velina			
2 sh and ie m	1	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailing Ad	dress (Street and Num	nberor <i>Rural R</i> ou shire Av	ite Number, City VC - An	or Town, State, Zip	attsville
C = 44 F		Gerardo Vasquez 20a. Method of Disposition	/Cousin	Md_ 21	1783	Date		Location - City or To	
Dermit. Pages 1 a Department of Hea mportant: if item nny injury or othe		1 XBurial 2 ☐ Cremation 3 ☐ R	lemoval from State	Place of Disposition cemetery, cremator					
permit. Pages 1 a Department of Hea important: if item eny injury or othe		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		eneal Co	emetery me and Address of Fac			nerl Hon	atemala
Deparimpour impour irrapour ir		Phillips 1	2010		304 Georg				
		23a. Part1. Enter the disease or compli	ications that caused the deat						Approximate
Disconini and		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.						Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq		d of Nec				
Examiner				,,					
	ner	Sequentially list conditions, if any, leading to ininediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of).					
cuted nd ransi	Examiner	that initiated events							
ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a conseq	juence of):					
I MECOTOS, P.O. DOX 00/00,  The law requires that the death certificate be executed ete has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	dicai		d					-	
BOX GO /	/Me	IF FEMALE:	3c. If ves. outcome of pregna	ancv	0 >5000			Ood Date of delice	
that the death cert ed by the ettendin detached for use	ian	in the past 12 months?	1 Live birth 2 Feta	il death 3 ☐ Ecto	pic pregnancy er (specify)			23d. Date of delive Month	Day Year
ched the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		or (specify)			72	
res thet the signed by this be detached	by Physician/Med	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the under	ying cause given in Pa	urt I. 2	23e. Did tobacco	use contribute to t	he cause of death?
necolus, he law requires t e hes been signe age 2 should be o							1 🗌 Yes	2 Dylo 3 Prot	bably 4 DUnknown
w requires been signatured in the should in	Completed					2	24a. Was an		opsy findings available
The la	E O						autopsy performed? Yes 2 10	death?	empletion of cause of
ysician: The lavysician: The lavysician; The lavysic certificete hes	0	25. Was case referred to medical			26. Pla	ace of Death (Che		10 ,,,,,,,,,	28.10
Physician:   Physician:   r this certifice	To B	examiner? 1 ☑ Yes 2 ☐ No	dospital: 1   Inpatient 2	ER/Outpatient 3	□ DOA Other: 4□	Nursing Home	5 🗌 Residence	6 ∰Other (Specia	(v) Scene
Attending Physician: or death. ector: After this certification by the funeral director,		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		Describe how in		1 1 1
INISION  or Attending after death. Director: After	catl	2 Accident investigation 3 Suicide 6 Could not be	8110103	6:53 /	1 ☐ Yes 2	/ -	uhject	assau	ctea
or Att	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fy)	actory, office	28f. L	ocation (Street a City or Town, Sta	and Number or Rura	al Route Number, w tawystwe
pitai ours a erai C		29a. Certifier 1☐ Certifying Phy	Parlies	2 Lot	used at the time, date	AV-	e Hyatt	sville 141	)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely tilled in by the funeral	edicai		sician: To the best of my kno ner: On the basis of examina and manner stated.	ation and/or investi	gation, in my opinion, o	death occurred at	the time, date a	nd place, and due t	o the cause(s)
To the within: To the	Me	29b. Signature and title of certifier		· ·	29c. License numbe	er	29d. C	ate signed (Month,	Day, Year)
F > F 0		A CAMAR A	0100 h 111	d	OCME		A	ugust, 11	. 2005
0 (2)		30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type, Prin		3.71	1 21		,
		A 1 - 5 1 1	1) (1)		111 D	Ctroot	Do1+imo	MD 21	1201
(3)		CHREI HALLAX	O me		111 Penn	Street	Dalthic	re, MD 21	LZUI

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Physician Month 2005 August 7:00 PM Barbara Jean Morgan /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Prince Georges Adelphi Heartland Health Care Center-Adelphi If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2□XF Director 11, 1943 Wash., 61 578-58-8983 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
Int: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow Jry or other traumetic event, the Medical Experiment man be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Funeral Director Washington DC. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20017 United States 501 Edgewood St., N.E. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 2 No t Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specity: Black Specify: Completed by 3 ☐ Widowed 4 1 Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12th Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sallie Coleman Ollie Morgan 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dana P. Morgan - Daughter 501 Edgewood St., N.E. #11, Wash., DC 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20c. Location - City or Town, State Depertment of Important: if to any Injury or o 8/13/05 4 ☐ Donetion 5 ☐ Other (Specify) Suitland, MD Cedar Hill Cemetery Stewart Funeral Home 22. Name and Address of Facility 21. Signatur of Fun al Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 11 Devoa 23a. Pert1. Enter the disease, or complications that caused the smith. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cau e (Final disease or condition resulting in death) /Medical Sepsis. Examiner Physician/Medical Examiner anding physician end use es the buriel-trensit Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in deeth) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuee of death? Myo Coordial interction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ģ sign. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Stroke Endstugn Roual disean. 1 Ves 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this Director: After this d in by the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending r death. 1 TYes 2 TNo investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 00054566 9/01 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) School Bhogovile 1220 A Earl Toppa Read Sieth 230, TO WION, MD 212 fg 2. Registrar's Signature 31. Date filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

State

Registrar

AUG 1 5 2005

		•	State of Mary  1 - State Registre MEND TIEM #19b Per FH  1 Decedent's Name (First, Middle, Last)	land / De	partment of Health and <b>artificate of Death</b>	Mental Hygier	2005	28193
H	Discontinuit				7.31707.011	2. Date of Death		3. Time of Death
	Physicia /Medic		John Joseph Maddo	ox, Sr.			2005	7:02 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	_	4c. County of Death	
	Funeral		Washington Adventist Hosi 5. Social Security Number 6. Sex 7. Age (In	oital yrs. last birthda	Takoma Pa-	rs. R Date of Birth	Mont go	lace (State or Foreign
	Director		578-42-4805 ¹\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	72 Yrs.	Months Days Hours Mi	reb. 25,	1933 Was	K., DC
	pur *		Usual Residence of Decedent         10a. State         10b. County         10	c. City, Town or	Location			Od. Inside City Limits
	Marylis f sho	Į.	District of Columbia	, ,	Washingto	n		1√2 Yes 2 □ No
	r 28e-	Director	10e. Street and Number		10f. Zip Code		Citizen of What Cou	ntry?
	th with	al D	103 - 15th St., S.E.		20003		United S	States
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 1	<ol> <li>Was Decedent of Hispanic Origin?</li> <li>If Yes, specify Cuban, Mexican, Pure Mexican</li> </ol>	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White,	can Indian,
36	rs afte	by Fu	1 □ Never Married 2 ☐ Married 1 ☐ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: BI	ack
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f show the Medical Exacilities and be notified at	ted t	15. Decedent's Education	16a. De	cedent's Usual Occupation	16b.	Kind of Business/In	dustry
215	thin 7.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life	ve kind of work done during most of work DO NOT use retired)		0	
	led wi			De	epartment of Publ	IC WOTKS		nment
anc	d be fi	Be C	17. Father's Name (First, Middle, Last)  Robert A. Maddox		To. Wother STA	Rosa B.		
Maryland	should nd Me mark	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	uins Address (Street and Number or	Rural Route Number, Cit	y or Town, State, Zij	Code)
	and 2 alth a 27 is ar trai		John J. Maddox, Jr Son		103 106 - 15th St., S			
Baltimore,	of He of He if Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Ob. Place of Dis cemetery, c	position (Name of rematory or other page in .	Date 20c.	Location - City or To	own, State
Ë	tment tant: tant:		`4 □ Donation 5 □ Other (Specify)	Quantic		/17/2005	Triangle	. VA
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic event. It a Medical Examination that the notified at once.		21. Signature of Funeral Service Licensee	TITU	22. Name and Address of Facility 4001 Benning Ro	Stewart Fur		20019
			23a. Part1. Enter the disease, or complications that caused the shock, or leaf failure. List only one cause on each line.	seath. Do not			511. 5 DC 2	Approximate Interval Between
	Physician		11	sicat	ion Promo	nomin		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a co					
ь		<u>-</u>	Sequentially list conditions, If any, leading to immediate Due to (or as a co	nse prence of	\$			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
oʻ	icate be executed physician and s the burial-transit	Еха	resulting in death) Last Due to (or as a co	nsequence of):				
38760,	cate by	dicai	d				-	-
•			IF FEMALE: 23c. If yes, outcome of p	regnancy			23d. Date of deliv	90/
Box	iaw requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months?  1 Vec. 2 Tello	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.O.	res that the de signed by the a i be detached f	hys	9 Unknown					
	es the	by	Part II. Other significant conditions contributing to death but no	ot resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	
ord	w require been sig should b	eted	Hyportension					
Records,	0 - 0	Completed				24a. Was an autopsy performed	prior to co	psy findings available impletion of cause of
Vital		e Co	25. Was case referred to medical		26 Place of C	1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 1 No
Š	× = =	OB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpat	Othor	Home 5 Residence	6 ☐Other (Special	(y)
n of	ding Phys h. After this funeral di	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Ye	28b. Time Injur		28d. Describe how in	njury occurred	
sio	r Attending or death.	icati	2 Accident investigation	A45 (	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Dur	al Couta Number
Division		Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (S	Specify)	street, ractory, office	City or Town, St		a noute Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	aic	29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, de	eath occurred at the time, date and pla	ice, and due to the cause	e(s) and manner as s	tated.
	the Ho hin 24 the Fu	ledical	(Check only one) 2 Medical Exeminer: On the basis of examiner and manner stated.	amination and/oi				
	To the Within To the	M	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month,	
n	(2)		30. Name and address of person who completed cause of death	(Item 23a) (Tur	ve. Print)	0	August 8	, 2005
1	- 2/		WAH ED. / 7600 Carro	III Ave	o-Takima	Punli mi	> 209	112-
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 5 2005	Signature -	rock			
			HOU TO FROM SOME	7				

			_ FOI	partment of Health and Mertificate of Death	Re	9.N2005 28194
	Physici		1. Decedent's Name (First, Middle, Last)  Jeanette E. Nordhoff		2. Date of Death Month Aug. 9	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Shady Grove Hospital	4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 579-48-4280 6. Sex 1 M 2 F 7. Age (In yrs. last birthda.	// If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Aug. 14	9. Birthplace (State or Foreign Country) 1932 Wash., DC
	ith the Maryland or 28a-1 show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Md. Montgomery	Location Rockville		10d. Inside City Limits 1X Yes 2 □ No
	3e or 28a st be notif	Funeral Director	10e. Street and Number 9701 - Veirs Drive	10f. Zip Code 20850	10	g. Citizen of What Country?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28a-f show says injury or other treumatic event, Its M. died Ex. in her mat be notified at ance.	by	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	filed within 72 he Hygiene ther than "netu int, Itse V. dical	Completed	(Specify only highest grade completed) (Gillier Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work. DO NOT use retired) Cretary	ring	6b. Kind of Business/Industry  Secretarial
	ould be filed Mental Hygid arked other atic event, II	Be	17. Father's Name (First, Middle, Last)  Frederick W. Nordhoff		e (First, Middle, M	aiden Sumame) erbacher
Maryland	2 should and Men is marke	10	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Run	al Route Number,	City or Town, State, Zip Code)
	Health tem 27 tem 27		20a Method of Disposition 20b. Place of Dis	7-Vintage Dr., F		, Ma . 20 / / 6  Oc. Location - City or Town, State
Baltimore,	Pages Iment of I tant: If it		'4 Donation 5 Other (Specify) Gate of	Heaven Cem.8/1	7/05	Silver Spring, Md.
Bal	permit. Pag Department Important: I any injury o QDCB.		1) h. M. au	22. Name and Address of Facility Hysong Co., Inc	c.	1
8760,	The law requires that the death certificate be executed  XE  XE  XE  XE  XE  XE  XE  XE  XE  X	ledicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter linderlying.	ory failu	ire	Onset and Death
.O. Box 6	that the death certifice led by the attending ph detached for use as the	Physician/Med		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
۵.	quires that in signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death? s 2 🖫 No 3 🗆 Probably 4 🗇 Unknown
Vital Records,	(0	Completed			24a. Was an autopsy perform	prior to completion of cause of
Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1   Yes   2   No	Othors	h (Check only one	nce 6 Other (Specify)
ou of	ding Phy h. After thi funeral o	ion: T	27. Manner 1 eath 1 **Natural 5 □ Pending (Month, Day Year)   28b. Time Injury	of 28c. Injury at	28d. Describe how	
Division	or Attendent fiter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital within 24 hours a To the Funerel Completely filled	edicai C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, de (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cal red at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
)	To the Vilhium To the Comp	W	29b. Signature and title of certifier  H. C. M.	29c. License number	29 A	d. Date signed (Month. Day, Year)  lugust 9,2005  Rochuille - MD
R	(6)		30. Name and address of person who completed cause of deat (Item 23a) (Typ	Shady Grove	Hosp	- Rochville - MD
	Sta Registi		AUG 1 5 2005	W.		

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** AUGUST 0 2005 8:30 MEN VAN NGUYEN /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SILVER SPRING MONTGOMERY SPRINGBROOK ADVENTIST NURSING HOME If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 1 M M 2 □ F Director 220-23-5860 VIETNAM 81 FEB. 21,1924 Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10a. State 10b. County 10c, City, Town or Location Item 27 is marked other than "naturel", or Items 23s or 28s-f show other treumstic event, the Mullical Examinar must be notified at MD MONTGOMERY 1 ☐ Yes 2 TNo SILVER SPRING Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11514 LOCKWOOD DRIVE 20904 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after a nand Mental Hygiene. Is marked other than "naturel", or Ites 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ASIAN þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ CASHIER 7-ELEVEN 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VAN T. NGUYEN THI UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr any injury or other treurr once OUYEN NGUYEN/SON 12112 ARBIE RD. SILVER SPRING, MD 20904 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State LOUDON PARK CREMATORY AUG 14,2005 BALTIMORE, MD 5 Other (Specify) \* 4 ☐ Donation 22. Name and Address of Facility HINES RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses Strwar Kenya 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Dementia dvanceo Sequentially list conditions, if any, leading to immediate these. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical the use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: or Attending Injury 1. Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide after Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3793 8/11/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ctr Dive Greenbeltho 20770 3 phanie 110 MD 7500 Greenway ot i +0 Pay, Year) 32 Registrar's Signature State 31. Date filed (Month Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28196 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James Earl 2005 2:15 p Parker August 12, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex X□ M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 579-12-5158 84 June 20, 1921 Maryland Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show 7 ia marked other than "natural", or items 23e or 28a-f shot traumatic event, 15, Nedical Examine or rust be notified at 1 ☐ Yes 2X No Directo Maryland | Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Freetown Rd. #302 21044 USA 2 should be filed within 72 hours after death on and Mental Hygiene.
Is marked other than "natural", or items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. XYes 2 □ No f Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: 1944–47 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Welder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be John Henry Parker Cora Elizabeth Canter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Tracie L. Six/ Niece 4102 Belle Farm Court Pylesville, MD 21132 of Health item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 15, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State = 5 permit. Page Department of Important: if any injury or once. 2005 \* 4 □ Donation 5 □ Other (Specify) Arundel Crematory Odenton, Maryland 21. Signature of Funerah Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 CIG MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzhei mer's Priysician Demention years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the . detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? pertension 1 ☐ Yes 2 💢 No 25. Was ase referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of - After 1 X Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 24 hours a 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 2 2 MID D56531 August 15, 2005 8+1E.6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, M.D. 10780 Hickory Ridge Road Columbia, MD 21044 egistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28197 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** Maurice ROSENBLATT 07:30PM Aug 11 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1**X**3M 2□F Director 90 Aug. 8, 1915 New York 057-12-8212 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "natural", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be motified at 1 ☐ Yes 2 No Maryland Rockville Director Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 6105 Montrose Road 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 □XYes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet College (1-4or 5+) Elementary/Secondary (0-12) Lobbyist Political permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other 1 any injury or other treumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Rosenblatt Katherine Golding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1275 K Street, NW, Suite 770, Washington, DC Jack Blum, POA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Mt. Lebanon Cemetery | 08/17/05 Adelphi, MD 21. Signature of Fyrana Service Licensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pneumona Aspiration **Physician** /Medical Due to (or as a consequence of) Dementia Examiner Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-transit Respiratory Due to (or as a consequence of P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Dyspiragia 3 Probably 4 □Ûnknown Completed cachexia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 3 DOA To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Stulpa amin, mo 08/12/05 00002713 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 6105 Montrose Road, Rockville, MD Shilpa Amin, M.D., 20852 31. Date filed (Month, Day, Year) AUG 1 5 32. Agistrar's Signature State Registrar

			1 - For State Registrar	State of Maryla		partment of H ertificate of L			ien 2005	28198
ı	Physici /Medic		1. Decedent's Name (First, Middle, La Benjamin	. Stokes				2. Date of Death Month Aug	2/ 200	5 645 AM
	Examir Funeral Director		4a. Facility Name (If not institution, given the factor of the factor o		s. last birthd	Months Days	Location of Death  OVE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County of De 10/1/2019 9. B	eath  Hithplace (State or Foreign Country)  Iaryland
a.	D D	<b>.</b>	Usual Residence of Decedent  10a. State 10b. County		ity, Town o					10d. Inside City Limits
-	with the Ma s or 28a-f s be notified	Director	MD. Hari		7 7	10f. Zip Code	hitefor		0g. Citizen of What	
. 98	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural; or items 23a or 28a-f show imatic event, it a Mydical Examination matter mat be multilised at	by Funeral	1803 Sus of  11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 \subseteq No If Yes, Give Year or Dates:		3. Was Decedent of Hi If Yes, specify Cuba	1160 spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wi	mencan Indian,
Maryland 21215-0036	vithin 72 hounder.  ne.  han "natura  e Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(G lif	cedent's Usual Occupa ive kind of work done de. DO NOT use retired	furing most of work )	ing	16b. Kind of Busines	ss/industry perdeen
and 21	t be filed water Hygier od other tiles event, IL.	Be	17. Father's Name (First, Middle, Las	Preston		est Drive	18. Mother's Name		faiden Sumame)	g Ground
Maryl	nd 2 should lith and Me 27 is mark r traumatic	10	Oscar  19a. Informant's Name/Relationship  Valerie Stokes	(Type, Print) Dau.				al Route Number,	City or Town, State	Kurtz A Zip Codel 20732 each, Md.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic en ODES.		20a. Method of Disposition  1 Burial 2 Cremation 3 Council Control Council Cou	□Removal from State	Place of Di cemetery,	sposition (Name of crematory or other place	• 8/2 is of Facility <b>J</b>	5/2005 arretts	Whitefo	or Town, State rd. Maryla Maryland
J.	Priysiciar /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	he					Approximate Interval Between Onset and Death
8760,	ate be executed sysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to time obligate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conse				V. 10 . 11		
P.O. Box 68	The law requires that the death certificate be executed tite has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of d Month	telivery Day Year
	w requires that the de been signed by the a should be detached t	þ	Part II. Other significant conditions Chronic Obstruc			/	en in Part I.			to the cause of death?  Probably 4 □Unknown
al Reco	ician: The law r certificate has be rector, page 2 sh	Completed		,				24a. Was ar autopsy perform 1 Yes 2	/ prior to	
Division of Vital Records,	ding Phys	ertification; To Be	25. Was case referred to medical examiner?  1  Solution Sol	28a. Date of Injury (Month, Day Year)	ER/Outpa 28b. Tim- Injur	e of 28c. Injury y Work	er: 4 □ Nursing Ho at ?? /es 2 □ No	28d. Describe ho	nce 6 □Other (Sp w injury occurred	
<u>N</u>	Hospitai or Attend 24 hours after death Funerai Director: tely tilled in by the	0	4 Homicide determined		ify)			City or Town	, State)	Rural Route Number,
34	To the Hospital within 24 hours a To the Funeral completely tilled	Medical	(Check only one)  2 Medical Exa  29b. Signature and title of certifier	miner: On the basis of examinand manner stated.	nation and/o	29c. License	pinion, death occur	red at the time, da	od. Date signed (Mo	nth, Day, Year)
			30. Name and address of person who Richard Evics	22 (		oe, Print)			Tug, 21 MD 212	
DH	Sta Regist MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year) AUG 2 9 2	32. Registrar's Sign	H.	parke				
					ORIGII	NAL				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 28199 Certificate of Death #1.Per Phys.PGC 8-15-05 cr 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year Rashid Springs 08 05 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CENTER YPUNCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 2 M 2 □ F Director None Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 28e or 28e-f ahow any injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f ahow the Medical Examiner must be notified at 1XX es 2 □ No Director Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11208 20720 Blue Fox Place. USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Derrick Clayton Denita Springs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1208 Flue Fox Place Bowie, Md. 20720 pate of Disposition (Name of Date 20c. Location - City or Town, State Denita Springs (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-10-05 4 □ Donation 5 □ Other (Specify) Riverdale Md. Riverdale Pk Crematory 21. Signatury of Funeral Se 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St. NW 20011 Do enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical hemon monan Examiner Due to (or as a consequence of). Physician/Medical Examiner attending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Ho 3 Probably 4 Unknown þ director, page 2 should be Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? >epsis 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ical Certification: To 1 Yes 2006 2 ER/Outpatient 3 DOA filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 (DNatural efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar JENNINGS

21. Date filed (Month, Day, Year)

AUG 1 5 2005

3001

Registrer's Signature

HOSPITAL DRIVE; CHEVERLY, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28200 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2005 GLADYS JEAN SPRINGBORN 12 August 05:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Riderwood Village Silver Spring If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Vrs Director 84 Jan. 8, 1921 579-18-1904 Berwyn, Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Silver Spring Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3160 Gracefield Road U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: à Specify: 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Department 12 Secretary it. Pages 1 and 2 should be filed variation of Health and Mental Hygientant: If item 27 is marked other tripury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Beveridge Annie Benny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lynn A. DeMeester, Niece 5137 Chowan Avenue, Alexandria, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) John's Church Cemetery 8/19/2005 Beltsville, Maryland permit.
Departri
Imports
any nju 21. Signal e Funeral Service Lonsee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 Willand (Mm) 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Arrhythmia /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consecuence of: burial-tran Due to (or as a consequence of): Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia; Osteoporosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2**X** No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onlone Hospital: Other: ျှ 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the,
within 24 hour.
To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one)

Division of Vital Records, P.O. Box 68760,



filed within 72 hours after death with the Maryland Hygiene.

Baltimore. Maryland 21215-0036

the death certificate be executed

attending physician

peeu

certificate

safter death.

or Attending Physician:

State Registra

29b. Signatur

address of person who completed cause of death (Item 23a) (Type, Print) Eugenio Machado, M.D. 3110 Gracefield Road, Silver Spring, Maryland 31. Date filed (Month, Day, Year)

AUG 1 5 2005

Registrar's Signature

29c. License number

D24035

29d. Date signed (Month, Day, Year)

August 12, 2005

			1 - For State Registrar	State of M	Maryland		artment of rtificate of				giene Reg. No.2	005	282	01
	Physici	an i	1. Decedent's Name (First, Middle,	Last)			SMITH	1		2. Date of Dea Month	ith Day	Year	3. Time of D	
	/Medic Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town,			109-25		2005 ounty of Death	17=38	
	Cxamii	1	HAZFORD MEN			Δ. 1.		LE O		RACE		2502	-0	
	Funeral			. Sex 7. A	ige (In yrs. la	st birthday)	If Under 1 Year	If Under	24 Hrs. P	Date of Birth	1	9. Birth	place (State or I	Foreign
	Director		017-28-5761	1 <b>½</b> M 2□ F	67	Yrs.	Months Days	Hours	Min. C	1/23/1	938	Conn	ecticut	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or Lo	cation						10d. Inside City	Limite
	Maryli f sho	ō	NC Onslow				onville						1 ☐ Yes 2	
	28a-	Director	10e. Street and Number			Jacks	10f. Zip Code				10g. Citizer	n of What Cou	ntrv?	
	h with	O IE	100 Sheffield Ro	ad			2854	6			_	S.A.	,	
	deat	Funeral	11. Marital Status	12. Was Deceden		. 13.	Was Decedent of If Yes, specify Cul		gin? (Speci	ify Yes or No-		Race - Ameri		
9	or Its	/Fu	1 ☐ Never Married 🏻 🏖 Marrie			i	i res, specily cui 1 ☐ Yes 2 🖸 No			can, etc.)		Black, White,	etc.	
ë	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates	:							Wh	ite	
7	"net	Completed	15. Decedent's (Specify only highest			16a. Deced	dent's Usual Occu kind of work done DO NOT use retin	ipation during mosi	t of working	,	16b. Kind	of Business/Ir	dustry	
7	withi ene. than	duc	Elementary/Secondary (0-12)	College (1-4o	r 5+)		.S. Gove				Mi	litary		
ğ	ould be filled within 72 hours after death with the Maryland Mental Hygiene. arkad other than "netural", or Itams 23e or 28a-1 show atic evant. It e Medical Exacilities transites neilling a	BeC	17. Father's Name (First, Middle, La					T		First, Middle,				
<u>a</u>	uld be Aenta rkad tic ev	To B	Francis Smith					Isol	lena S	Scipion	e			
Maryland 21215-0036	and s m		19a. Informant's Name/Relationshi	(Type, Print)	1	19b. Mailir	ng Address (Stree					own, State, Zip	Code)	
	as 1 and 2 of Health I itam 27 i		Ruby Smith (Wife	:)			Sheffie	ld Roa						
altimore,	Pages 1 nent of H int; ff ital		20a. Method of Disposition 1 □Burial 2 □ Cremation 3	Annoval from State			sition (Name of natory or other pla DLINA State	(e)	Dat	te	20c. Locat	ion - City or To	own, State	
<u>E</u>	tmen tant: jury		`4 □Donation 5 □ Other (Spe			ans Cen	netery	ļ0	8/19/20		Jacksc	nville,	VC	
Ba	permit. Pages Department of Important; if i any injury or one		21. Signature of Funeral Service Li	3 1 / m	2 40	Ta	. Name and Addr	ess of Facilit O <b>Funer</b> a	al Home	e, P.A.			_	
			29a- Part1. Enter the disease, or o	omplications that cause	ed the death.		3 South Page of dy					and 2100	Approximate	
	Dhysisian		shock, or heart failure. List or Immediate Cause (Final	lly one cause on each	line.								Interval Betwe Onset and De	
	Physician /Medical		disease or condition resulting in death)		s a conseque		<u> </u>							
и	Examiner			200.0 (0. 0										
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	nce of):		_						
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
60,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	E	resulting in deathy Last	Due to (or a	s a conseque	nce of):						I		
98760	physi physi	dical		d										
×	eath certific attending p for use as	ian/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnanc	cy					234	. Date of delive	an.	
Box	death a atter d for u	iciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 🗌 Fetal d	eath 3	Ectopic pregnand Other (specify) _	у			230	Month	Day Yea	ar
J.	at the de by the a tached	Physici	9 Unknown	9□ Unknown										
	res that igned to be det	by P	Part II. Other significant condition			-					bacco use	contribute to the	ne cause of dea	th?
g	w require been sli should b		Speazon	AZY AZI	End B	YPA.	ss Sunc	iny G	2451	1 □ Ye	es 2□N	lo 3 Prob	ably 4 🕮 Ink	nown
<b>Hecords</b> ,	law ras be	Completed								24a. Was a autops		4b. Were auto	psy findings ava mpletion of caus	ailable se of
	The lav	Con								perform	med? 2. ■ No	death? 1 🔲 Yes		
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	_					Check only on				
0	chis al dir	. To	1 Syes 2 No 27. Manner of Death	1 ☐ Inpat		VOutpatien  8b. Time of	1 3 DOX					Other (Specif	y)	
	ding I h. After funer	tlon	1 Natural 5 ☐ Pending	(Month, D	ay Year)	Injury		nyat nrk? ]Yes 2 □ h		d. Describe ho	ow mjury oc	currea		
DIVISION	or Attanding ifter death. Diractor: After in by the funer	fica	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of Ir	njury - At hom	e, farm, stre	et, factory, office			f. Location (St	reet and N	umber or Rura	l Route Number	r,
5	s afte	Certification;	4  Homicide determin	building, e	etc. (Specify)		,			City or Towr	n, State)			
	To tha Hospitel or Attani within 24 hours after deatl To tha Funaral Diractor: completely filled in by the	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	Physician: To the bes	of examinatio	edge, death n and/or inv	occurred at the trestigation, in my	ime, date and opinion, deat	d place, and th occurred	d due to the ca at the time, da	ause(s) and ate and pla	d manner as s	ated. the cause(s)	
	To tha within 2 To tha complet	Mec	29b. Signature and title of certific	and manner s	nalou.		29c. Licen	se number		2	9d. Date si	gned (Month,	Day, Year)	
	->-0		Manstal &	when	M	2	0 2	11800	7	^	1	7 16		
			30. Name and address of person wh	o completed cause of				-	•	·+	-905		2063	
1	M	8	G.S.PLASHJ	M.D 2	336 Y	ONIC	2020	TIN	الموم	Um N	102	1593		
	Sta	100	31. Date filed (Month, Day, Year)	32. Regis 8 2005	ar's Signatur	re <b>4</b>	1 12							
	Registr	ar	MUG I	o chas	MARIE	1	Book							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 7:20 A 10, 2005 Alma Davis Sisk August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 3401 South Leisure World Blvd Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Director 93 172-03-1058 10/31/1911 Pennsylvania Usual Residence of Decedent with the Maryland 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3401 South Leisure World Blvd or Items 23e 20906 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Interportent: if item 27 is marked other than "neturel", or itel may intry or other treumatic event, the Wedical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☐Widowed 4 ☐ Divorced Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gomer Davis Margaret Ethelyn Hughes 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Rohrbaugh - Daughter 402 Whitestone Rd; Silver Spring MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State d Rock Creek Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 8/13/2005 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Myelint 11800 New Hampshire Ave; Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Years Congestive Heart Failure
Due to (or as a consequence of): /Medical Examiner Years Critical Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physiclan/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate I 2 □ No Division of Vital 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 2 4 ☐ Nursing Home 5 🏲 Residence 6 ☐ Other (Specify) 1 Tes 2 XNo 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 1 ZNaturai 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical mpletely (Check only one) To the the within 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 D43202 August 11, 2005 my ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 3305 North Leisure World Blvd 8 O Zanne Mankfard M.D. Charlene Silver Spring, Maryland 20906 Year) 5 32. Registrar's Signature State FELLEN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28203 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:30 2005 10, Η. Scurlock August George /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Manor Care Chevy Chase B. Date of Birth (Month, Day Year) 4. Aug. 29, 1919 Washington, DC Il Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) Sociel Security Number **Funeral** Months 578-18-8394 85 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Menfal Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exammer must be notified at TY Yes 2 No Maryland Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 2201 Colston Drive #711 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No **Black** Baltimore, Maryland 21215-0036 Specify: Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Photographer Visual Arts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Essie Fearing Addison N. Scurlock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1220 East West Highway #507, Silver Spring, MD 20910 Jacqueline Colbert / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/15/05 Rock Creek Cemetery Washington, D.C. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service SUC 8 small 7400 Georgia Ave. N.W., Wash. D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1219 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner use as the burial-fransit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year į in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by page 2 should be 3 Probably 4 Donknown 1 Yes 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No or Attending Physician: funeral director, 25. Was case relerred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 4₽ Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1- Natural Injury 5 Pending 1 ☐ Yes 2 No investigation hours after death. 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D0054566

State Registrar 31. Date liled (Month

20

1220 A Egit Toppa Road Seeh 230, towson, MJ 2/2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3hogavile

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yeer Month **Physician** 4:45 A M Gladys Ruth Stewart August 15 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 3345 N. Chatham Road, Apt.D Ellicott City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🔀 F Director 212 01 7409 87 3/14/1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Itam 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event. The Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3345 N. Chatham Road, Apt.D 21043 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be pe q permit. Peges 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic avoice. Agnes M. Chariton Edward V. Roselius ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106 Cottage Hill Court Eldersburg, MD 21784 Barbara B. Schmidt/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State Moreland Mem. Park 8/18/2005 Parkville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee s-nett MOLO 49 4112 Old Columbia Pk. Elliott City, MD 21043 23a. Part1. Enter the disease, or complications that drused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CNS Physician Lymphomo weeks resulting in death) /Medical Examiner months Non Hodakins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown δ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 1 Yes 225 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home \$ Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 ☐ Accident investigation the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) ţ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD D45274 8/15/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caronsville MD 21278 #301 Rd1.71 Mauna 516 gistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 6 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** VICTORIA S. TRICKAY AUGUST 12 2005 9:12P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WILLIAM HILL MANOR EASTON TALBOT 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 X F Months Hours 155-36-4800 Yrs. Director <u>10</u>2 DEC 8 1902 NEW JERSEY Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or Items 23e or 28e-f show traumetic event, the Mudical Exeminar must be notified at MD TALBOT EASTON 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE, APT. 200 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after tal Hygiene. I Hygiene. I other than "naturel", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 ☑ Widowed 4 □ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Heath and Mental Hy, Important: If Item 27 Is marked othe any injury or other traumetic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK STARK LOUISE PETER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMUEL LYLES FREELAND/EST. P.R. PO BOX 724, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) OXFORD CEMETERY 8/18/2005 OXFORD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERO JOHN R 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER **Physician** disease or condition resulting in death) SYCAUS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 Yes \$2**X**VIO or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 5 Residence 6 Other (Specify) 2 2 ER/Outpatient funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospital o within 24 hours aff To the Funaral Di completely tilled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ja 2 Martin 2005 Registra Signature 31. Date filed (Month, Day, State Registrar

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H	lealth and M Death	lental Hygi	en 2005	28206
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	n. v	3. Time of Death
	Physicia /Medic		Harold Wateman	n Thompson				August	12 2005	9:47 a™
	Examin	er	4a. Facility Name (If not institution, give s			- "	Location of Death		4c. County of Death	•
			Continuum Care 5. Social Security Number 6. Sex		. last birthday)	Sykes If Under 1 Year	sville	8 Date of Birth	Carrol 9 Birth	
	Funeral Director			M 2□F	7 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Coul	place (State or Foreign htry) WV
		ŀ	Usual Residence of Decedent				I. I. IVC	ivember		
	how		10a. State 10b. County		ity, Town or Lo					Od. Inside City Limits
	e Ma 3a-f s	Director	MD Howard	ı <u>F</u>	ILLICO	tt City				1 ☐ Yes 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	s 23s		11516 East Wind	hester Lar 12. Was Decedent Ever in		210		acify Vas or No-	USA 14. Race - Ameri	can Indian
36	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Mydicul Ever if or must be neilified at event.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  Tyes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	Rican, etc.)	Black, White,	
Maryland 21215-0036	2 hou	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	ation	ring 1	6b. Kind of Business/In	dustry
215	thin 7 e. an "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-40r5+)	life.	DO NOT use retired	1)	ig	Home /T i	e
21	e filed within al Hygiene. I other than vent, the My	Con			Inst	urance A		(5)	Home/Li	re
Ind	tal Hydral Hydral even	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M		
Z	2 shoutd be and Mental is marked o	<sup>L</sup>	Earl Thompson  19a. Informant's Name/Relationship (Ty)	no (Print)	10b Mailie	na Address (Street		Davids	SON City or Town, State, Zij	Code) 21 0 / 2
Ma		8 0	Candy Thompson/		1					tt City,M
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		20a. Method of Disposition			osition (Name of matory or other place			toc. Location - City or T	
UOL	ages ent of nt: If i		1 Burial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)	emoval from State		d Vetera	l l	/05 CF	eltenham	Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service License	M00945	A)	2. Name and Addre REHART – B	ss of Facility ECHOLS F	UNERAL	HOME, P.A	•
	_		23a. Part1. Enter the disease, or compli	cations that caused the de	ath. Do not ent	. O . BOX ter the mode of dyin	g, such as cardiac	or respiratory arre	MD 20646	Approximate Interval Between
	Physician		shock, or heart failure. List only or Immediate Cause (Final	A	500001	500 00	O disease			Onset and Death
8	/Medical		disease or condition resulting in death)	Due to (or as a conse	Sp. rat	(0)(	ejmonio	·		THE MONEY
į.	Examiner		Sequentially list conditions		stroke					
Ŀ	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
	cate be executed physician and the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a cons	equence of):			-		
8760,	be ex ician burial			550 10 (01 40 4 55.15	400.100 01,1					
687	phys phys s the	edicai		J						
.O. Box (	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of deliv Month	ery Day Year
0	that the by detail		Part II. Other significant conditions cor	ntributing to death but not r	esulting in the u	ınderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	he cause of death?
rds	quires t	d by						1 ☐ Ye	s 2□No 3□Pro	pably 4 Unknown
Vital Records,	law requir as been si 2 should I	Completed						24a. Was ar		opsy findings available ompletion of cause of
Re	The la	шо						autopsy perform	ned2 death?	2 No
ita		O	25. Was case referred to medical				26. Place of Dear	th (Check only one		
	S S	To B	examiner? 1 ☐ Yes 2 ☑ No	fospital: 1   Inpatient 2	☐ ER/Outpatie		4 Nursing H	ome 5 Reside	nce 6 Other (Speci	(y)
n of			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		-		Yes 2 □ No	Ont Lauretine (Ch		of Courts Number
Division	of or Attendate death Director: /	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st cify)	reet, factory, office		City or Town	eet and Number or Rur , State)	ai Houte Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examinate	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deal nation and/or in	th occurred at the time timestigation, in my o	me, date and place, ppinion, death occur	and due to the ca rred at the time, da	use(s) and manner as s ite and place, and due t	stated. o the cause(s)
	o the vithin : o the omple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	od. Date signed (Month,	Day, Year)
	FSFÖ	1 10	) say	maleted cause of death (I	om 22a\ /T	Dax Brief)	ウエナノナスロ	1 1	vg057 12,	2005
3	BIREL	l i	30. Name and address of person who co	1380 Proc	del ma	stiv2 .	106 EK	enchune	is am	184
	Sta	ite	31. Date filed (Month, Day, Year)	32. Recorrar's Sig	nature	+		71	-	
	Regist		AUG 152	32. Recorar's Sig	· K	belle.				

		1	For State Registrar	State of Marylan	d / Departm <i>Certific</i>	ent of Health and ate of Death	Mental Hygier		28207
	Physiciai /Medica Examine	n al -	Decedent's Name (Plist, Middle, Last,     A. Fecility Name (If not institution, give)	JUANITA	TYN 4b. C	City, Town, or Location of Des	fugust	Day Year 12, 24)0 4c. County of Death	3. Time of Death 06,30 Å M
	Funeral Director		5. Social Security Number 6. Se 10 Usual Residence of Decedent	ON HWE x 7. Age (in yrs. i JM 2数F 90	last birthday) If Ui Yrs. Mon	nder 1 Year If Ønder 24 Hr ths Days Hours Mir		9. Birth	place (State or Foreign Intry)
	within 72 hours after death with the Maryland ena. than "naturel", or Itams 23a or 28a-f ehow he Madical Examber must be notified at	Director	10a. State 10b. County (CCC)	10c. City	V. 76 m or Location	SUN			10d. Inside City Limits 1 ☐ Yes 2 1 No
	leath with ti ms 23a or 2 must be n	Funeral Dir	10e. Street and Number 134 Shell  11. Marital Status	TON LAWE  12. Was Decedent Ever in U.		ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue		Citizen of What Cou	ican Indian,
0036	ours after ourel; or Itan	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1 □ Y∈	es 21 No Specify:		Specify: (1)	hile
21215-0036	d within 72 h piena. r than "natu	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's (Give kind o life, DO NO	Usual Occupation (work done during most of w of use retired)  (MKMAKKE)	orking 16b.	. Kind of Business/li	ndustry
Maryland 2	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiena. If item 27 ie marked other than "naturel", or Itams 23a or 28a-f ehow or other traumatic event, the Madical Examinar must be notified at	To Be C	17. Father's Name (First, Middle, Last)	3A FARM	METR	MA	ame (First, Middle, Maid	ve >	
	1 and 2 sho Health and em 27 le ma ther traum		19a Informant's Name/Relationering (T)  20a. Method of Disposition	PCR5 20b. P	134 S	r ss (Street and Number or MNE) (Name of	KISING	y or own, State, Zi	21911
Baltimore,	Par Fr		1 Burial 2/3 Cremation 3 5 Other (Specify, 21. Signature of Funeral Service License	Removal from State	AUS CREN	or other place)  MAICRY  By  and Address of Facility	5/05 Le	ola, KA	
B B	permit. Departr Importe eny inji		23a. Part 1. Enter the disease, or comp	Illa/	CO//	INS FULLY A	Home O	factite	19363 Approximate
•	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	derma	mode of dying, soon as earth	ac or respiratory arresty		Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of the	b. Due to (or as a conseq	uence of):				
8760,	bur join	icai Examine		c.  Due to (or as a conseq d.	uence of):				
P.O. Box 68	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	23c. If yes, outcome of pregna 1	I death 3 □Ectop	oic pregnancy r (specify)		23d. Date of deliv	very Day Year
	w requires that been signed be should be deta	ρ	Part II. Other significant conditions co	ontributing to death but not res		,	23e. Did tobacc	couse contribute to	
Division of Vital Records.	ysicien: Tha law requisic certificate has been director, page 2 should	Completed					24a. Was an autopsy performed 1 Yes 2	prior to co death?	opsy findings available ompletion of cause of 2 No
f Vit	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Othor	eath (Check only one)  Home 5 Residence	6 □Other (Spec	ify)
o uo	ding Phith. After thi		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
Divisi	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined		ome, farm, street, fa	ctory, office	28f. Location (Street City or Town, St.		ral Route Number,
	Hospitel 24 hours a Funerel I	edicai		ysicien: To the best of my kno liner: On the basis of examina and manner stated.					
	To the within 2 To the comple	Me	29b. Signature and title of certifier	41.3		29c. License number		Date signed (Month	
	4		30. Name and address of person who o	completed cause of death (Item	n 23a) (Type, Print)	n Chesape	1 .1	745112,	2005
	Stat	te	Harks, MD 31. Date filed (Month, Ruggest) 5	2005 32. Redustrar's Signa	Norther ature	n Chesape	elle Hospic	e, EIKI	on, MD
	Registra			LUUS Bloken	J. 600	all I			

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of rtificate of			Reg. No. Z	005			
	Physici	an	1. Decedent's Name (First, Middle, Las.	,				2. Date of De. Month August	Day	Year	3. Time of Death  8:35 A <sup>M</sup>		
	/Medic Examin	al	Phyllis Lucille  4a. Facility Name (If not institution, give	Thomas		4b. City, Town,	or Location of Dea			unty of Death	0:33 A		
	Examili	ICI	Holy Cross Hospit			Silver			Moi	ntgomer	У		
l	Funeral Director		5. Social Security Number 6. Se 455–60–9930	7. Age	(In yrs. last birthday) 63 Yrs.	Months Day			1942	9. Birthpl Count Mary	ace (State or Foreign try) Land		
	land		Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo	ocation				10	d. Inside City Limits		
death with the Maryland	Mary Iled	to	Washington Thursto	n	01ympia						1 Yes 2 □ No		
	or 284	Directo	10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?					
	sath w	Funeral D	417 Decatur Stree	12. Was Decedent E	iver in U.S. 13	98502	Hispanic Origin? (		USA 14.	Race - America	an Indian.		
30	n 72 hours after death with the Marylan "natural", or Itema 23a or 28a-1 show saftal Eraminat must be notified at	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▓ Divorced	Armed Forces?  1  Yes 2 XN  If Yes, Give  Year or Dates:	0	If Yes, specify Co	ıban, Mexican, Pue	rto Rican, etc.)		Black, White, e ecify: Whit	etc.		
215-0036	'2 hou latura		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occ	upation	orkina		of Business/Ind			
7	within 7 ene. than "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12  (Give kind of work done during most of working life. DO NOT use retired)  Administrative Assistant  Reference of the completed of the completed of the complete of th							Estate			
2 2	Hygier ther ti	e Cor	17. Father's Name (First, Middle, Last)		Admin	ISLIALIV		ame (First, Middle,					
and	ld be l ental I ked o	To Be	William Douglas B	utlor			Lucille						
Mary	and M s mar	-	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Stre	et and Number or F		er, City or To	wn, State, Zip	Code)		
Σ,	and 2 lealth m 27 i		Joseph William But	ler/son	417 I		Street NV			nington			
altimore,	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any njury or other traumatic event, the Media 2006.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		W. Arunde	matory or other p el Crema	tory		0dent	on, Mar	yland \		
Rall	permit Depen Import any n		21. Signature of Funeral Service Licen	tolth	MO1251 Be	everly L	ress of Facility e Cremati . Heckrot	te, P.A.	Clark	.0. Box sville	, MD 21029		
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	rest,		Approximate Interval Between Onset and Death Hours							
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):										
	Examine.	-	Sequentially list conditions, if any leading to immediate	Due to (or as a	consequence of):			House					
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
Ď,	e exec ian an ırial-tr	Exa	resulting in death) Last	Due to (or as a	consequence of):								
09/g	cate be executed physician and the burial-transit	dical		d									
. Box 6	it the death certific by the attending p tached for use as	Physician/Me	in the past 12 months?	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year			
5	d by the		9 Unknown  Part II. Other significant conditions co		it not resulting in the i	Inderlying cause	given in Part I	23e Did t	obacco use	contribute to th	e cause of death?		
ords,	The law requires that ste has been signed b page 2 should be dete	ted by	Part II. Other significant conditions of	onthodding to death of	at not resulting in the c	andenying cause	givon at Parts.			lo 3 Probi			
Vital Records,		Completed				-		24a. Was autor perfo	an 2 ssy med? 2.2 No	4b. Were autor prior to con death? 1 ☐ Yes	osy findings available inpletion of cause of		
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospitaf:		_	)ther	eath (Check only o					
Ö	Phy rathis	lon: To	1 ☑ Yes 2 ☐ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		of 28c. In	jury at vork?		tome 5 ☐ Residence 6 ☐ Other (Specify 28d. Describe how injury occurred		')		
Division	Attended of deat sctor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	9 200 Place of Injury At home farm street featon, office 2					18f. Location (Street and Number or Rural Route Number. City or Town, State)				
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C		Thysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Imminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date si	igned (Month, l	Day, Year)		
)_			D. Vilvamas	atya Reddy	1 NO	D43464			AUGUST -12-2005				
9	66		30. Name and address of person who	completed cause of de	eath (ftem 23a) (Type,			0	_				
	Sta	ato	VIKRAMADITYA · D. R. 31. Date filed (Month, Day, Year)	32. Re stra	OCKVIVE F	THE, SU	[1E208,	KOCKVIU	e, ND	10852			
	Regist		31. Date filed (Month, Day, Year) AUG 1 6	2005	tr's Signature	well							

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar 28210 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year /Medical Rosie Ellen Ward 10 2005 7:00 A August 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Millenium Health & Rehab. Center Ft. Washington Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours 1 M 2 K Yrs Director 216-40-7817A Apr. 15, 1913 Maryland Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, it is Michical Examiliar must be remitted at Directo Maryland Prince George's 1 ☑ Yes 2 ☐ No Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12021 Livingston Road 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene. "Natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 TNo Specify: 3 → Widowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hient: If item 27 Is marked out Benjamin Jones Mamie (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Robertson/Daughter 2005 Jessica Lane, Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State artment of ortent: If i injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial park 8/15/2005 Landover, MD permit.
Departn
Importe
any inju 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility Stewart Funeral Home M 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day 4☐Pregnant at time of death Year signed by the at Id be detached fo 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Congestive Heart Failure 1 Tes 2 No 3 Probably 4 Unknown Completed been Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending After 5 Pending investigation 1 Natural s after death. 1 □ Yes 2 □ No in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 / Homicide Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI D42955 August 12, 2005 30. Name and address > per on who comply ed ause of death (Item 23a) (Type, Print) Edger V. Potter, Jr., M.D. 1328 Southern Ave., S.E. #210, Wash., DC 20032 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2005 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Departme

Certifica

ent of Health and N			
ate of Death	Reg. No. 2	005	28211
	2. Date of Death	Xear	3. Time of Death

Physic /Medi Exami

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any hjury or other traumatic event, the Modical Examinant could be notified at once.

Jean Evon WEAVER

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

П	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of									3. Time of Death					
an	JANE EV	VON WEAVE	ER			Aligust 10, 20			2005	5 4:10 P M					
al er	4a. Facility Name (I	f not institution, giv	ve street and number,			4b. City, Tow	m, or Loc	cation of Death	0	4	c. Cou	nty of Death	th		
	Doctor's	s Communi	ity Hospit	a1		Lanl				Prince			orge's		
	5. Social Security N		Sex 7. As 1□M 2XTF	hday)	If Under 1 Y Months Da		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da	irth 9. Birthplace (State or Foreig Country)						
	183-44-5155   Feb. 3, 1953   Pe											Penn	nnsÿlvania		
	Usual Residence of 10a, State	10b. County		10c. City, Town	or Lo	cation						10d. Inside City Limits			
ŏ	MD										1X Yes 2				
rect	MD 10e. Street and Nur		seorge s	COTTER	C 1	10f. Zip Coo	de		Т	10a. C	Og. Citizen of What Country?				
ā			troot			740			U.S.A.						
era	11. Marital Status	skogee St	12. Was Decedent		13. V	Vas Decedent	of Hispa	nic Origin? (Sp	ecify Yes or No		14. F	Race - Ameri			
Fur	1 Never Marr	ied 2X Married	Armed Forces'			rYes, specify ( IDYes 2 <b>X</b> D		lexican, Puerto	Hican, etc.)			Black, White,	etc.		
by	3 🗆 Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:			I⊔ Yes 2AL	No 5	pecify:			Spe		ite		
Completed by Funeral Director	(Spec	15. Decedent's E		16a.	(Give	lent's Usual Or kind of work de	one durin	n ig most of work	ing	16b.	Kind of	Business/Ir	ndustry		
ם	Elementary/Seco	ndary (0-12)	College (1-4or			DO NDT use re	itired)			_	T 3.6				
ပိ	17. Father's Name	/First Middle Lac	*)	A	cco	unting	18	Mother's Name	a (First Middle			ariott	<del>-</del>		
Be			1)					Melda W		, waite	iii Juii	ianie)			
ဥ	Kenneth		(Type Print)	19h	Mailin	a Address (St		Number or Run		er City	or Tox	um State Zi	n Code)		
		. Weaver	-										Land 20740		
	20a. Method of Dis		, spouse	20b. Place of	Dispo	sition (Name o	f		Date			n - City or T			
		Cremation 3 ( 5 ☐ Other (Speci	Removal from State		cemetery, crematory or other place)					4/2005 Alexandria, Vir					
	21. Sign of FC	mecropo.	opolitan Crematory   08/14/2005   22. Name and Address of Facility Gasch's Fu												
	(dasch s ruheral he									-					
	23a Part   Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate														
	Onset and Death														
	disease or condition resulting in death)  Due to (or as a consequence of):											3month 1			
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):														
cause. Enter Underlying Cause (Disease or injury that initiated events  c.															
EX	resulting in death)	Last	Due to (or as	a consequence of	ot):										
an/Medicai			d												
/Me	IF FEMALE:		23c. If yes, outcome	of prognancy											
	23b. Was deceden in the past 12	months?	1 ☐ Live birth	2 □ Fetal death t time of death	th 3 Ectopic pregnancy					23d. Date of Month			Day Year		
Physic	1 ☐ Yes 2] 9 ☐ Unknown		9□ Unknown	titile of death	tth 5 ☐ Other (specify)										
/Ph	Part II. Other signif	icant conditions	contributing to death I	out not resulting in	the ur	e underlying cause given in Part I. 23e. Did					tobacco use contribute to the cause of death?				
Completed by	Coa		10)					Yes 2 No 3 Probably 4 € Inknown							
iete					242					24a. Was an 24b. Were aut			topsy findings available		
mc		·		au pe						prior to co death?	mpletion of cause of				
C	25. Was case refer	red to medical					26	. Place of Deatl							
To Be	examiner? 1 ☐ Yes 2 ☑		Hospital: 1 Inpati	ent 2 ER/Ou	tpatien	t 3 DOA	Other			esidence 6 Other (Specify)					
n; T	27. Manner of Deat	h	28a. Date of Inj	ury 28b. T	ime of								,,		
atio	1 ☑Natural 2 ☐ Accident	5 Pending investigation		28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28c. Injury at Work? 1											
tific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not I determined	28e. Place of In	jury - At home, fai tc. (Specify)	rm, stre	eet, factory, off	ice		28f. Location (- City or To			mber or Rur	al Route Number,		
Medical Certification;															
cai	29a. Certifier (Check only	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis of	of my knowledge	, death	occurred at the	e time, o	date and place,	and due to the	cause(	s) and	manner as s	tated. o the cause(s)		
ledi	one)		and manner s												
-	29b. Signature and	A L					ense nu	696		29d. Date signed (Month, Day, Yo					
	7 600		mp.							0	110				
			completed cause of	death (Item 23a) (	Type,	Print)	PAL	luan	taren hu	11	MI	5.20	OFF		
-	GULDECP S. LITHABORA, 7247 Hanove Phikman, Grenbelt MD. 20770  31. Date filed (Month, Day, Year)  32. Registrar's Signature														

State Registrar

AUG 1 5 2005

			For State Registrar	State o	f Maryland /	•	artment of H rtificate of L			giene Rag. No.		
e.	Physici /Medic		1. Decedent's Name (First, Middle, Las EARLE	De		2. Date of De Month	Day U	05	278-20-4112 18:30M			
	Examin	er	4a. Facility Name (If not institution, give WASHINE-TON AL					- 4				DHERY
	Funeral Director		213 10 70 17	ex FM 2□F	7. Age (In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da OCL 8	1933	9. Birthp Court Nort	place (State or Foreign Carolina
	a Marylend e-f show	ctor	Usual Residence of Decedent  10a. State North  Carolina Northa	mpton	10c. City, To	wn or Lo		Rich Squa	re		1	0d. Inside City Limits 1 ☐XYes 2 ☐ No
	h with th	ai Director	10e. Street and Number 108 Small	wood St	<b>:</b> .		10f. Zip Code	27869		10g. Citizen of		ntry? States
36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylend Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or itams 23e or 28e-f show any injury or other treumatic event, it is Marked Exa unstrument indifficult at ODGs.	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ₩ Widowed 4 □ Divorced		edent Ever in U.S. prces? 2 XNo ve	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Ra Bla Speci	ce - Americack, White,	
1215-00	vithin 72 hou ne. hen "neture e Madical E	Completed	15. Decedent's Ec (Specify only highest gra			(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of work )		16b. Kind of E		
	a filed wall Hygier I other the	Be Co	6th 17. Father's Name (First, Middle, Last)				Custod	ial Worke 18. Mother's Nam			ool Sy me)	rstem
ıryla	should b nd Ment: marked imatic e	To	Rex Ward		19	b. Mailir	ng Address (Street a	and Number or Rui		e Harvey		Code)
	and 2 fealth a m 27 is		Phyllis W. Lock	e – Dau			08 Smallwesition (Name of		Rich So	quare, N		7869
more	Pages 1 ient of H nt: If ite ry or ot		20a. Method of Disposition  1		State cemet	ery, crei	natory or other place	Øem.	3/2005			re. NC
Balti	permit. Departminimports any inju		21. Signature of Foreral Service Licer	Jeuga W	A TIL		2. Name and Address		ewart I	Tuneral	Home	
	Physician		23a. Part1. Zhter the disease, or com shock of heart failure. List only Immediate Sause (Final disease or condition	olications that cone cause on e	each line.		er the mode of dying				TASE.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequence					,		
,09	cate be executed physician and sthe burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence							
Box (	death certifi e attending ed for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1☐Live t	tcome of pregnancy birth 2 Fetal dea nant at time of death own		Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
S, D	iaw requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions of	ontributing to d	eath but not resulting	in the u	nderlying cause give	en in Part I.		obacco use con Yes 2 □ No	tribute to th	ne cause of death?
Œ	The ate h	Completed						***************************************	24a. Was auto perfo 1 \( \text{Yes} \)		Were auto prior to cor death? 1 \( \text{Yes} \)	psy findings available mpletion of cause of
Vita	Physician: The ta r this certificate ha ral director, page 8	o Be (	25. Was case referred to medical examiner? 1 ▼ Yes 2 □ No	Hospital:	Inpatient 2 ER/0	Dutantina	nt 3 DOA Othe	26. Place of Deal		one)	has (Sagaih	
of	ding PI h. After ti funera	-	1 Xes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon		. Time o Injury	28c. Injun Work	-		how injury occu		7
Divis	i Diffe	Certification:	3 Suicide 6 Could not b 4 Homicide determined	280. Place	of Injury - At home, ing, etc. (Specify)	farm, str	eet, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rura	il Route Number,
Division of Vital Records, P.O. Box 68760,	ne Hospital 24 hours a ne Funerei I	Medical C	29a. Certifier Check only one) Certifying Ph	niner: On the b	e best of my knowled easis of examination a liner stated.	ge, deati and/or in	n occurred at the tim vestigation, in my of	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as si and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title on certifier				29c. License	e number		29d. Date signs	ed (Month,	Day, Year)
•			30. Name and address of person who	completed cause		) (Type	Print)	60019	7	00	as	2005
R	(10)		30. Name and address of person who  DARCE  31. Date filed (Month, Day, Year)	n 4	AMMA Registrar's Signature	- N		iccard Dr	·•• #202	, Rockv	ille,	MD 20850
	Sta Regist		AUG 1 5 200		w At	los	W					

State of Maryland / Department of Health and Mental Hygiene 2005 28213 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2005 August 10 7:30 a.M Mildred Elizabeth Willev /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Chesapeake Woods Center Dorchester Cambridge If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 M 2 X F Yrs 94 1911 Maryland Director 216-07-7234 April 3, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h Counts r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 □ No MD Dorchester Cambridge Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 525 Glenburn Ave. 21613 USA Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: white Specify: Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 seamstress garment 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hamilton Jackson Manning Eva McCollister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Bellevue Ave., Cambridge, MD Jesse Hurley Jr. son 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Memorial Park 8/12/05 | Cambridge, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature : Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** Week disease or condition resulting in death) /Medical Due to (or as a consequence of) Vascular disease Examiner schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit attending physicien and resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has autopsy performed? Yes 2 No 1 Yes Division of Vital : After this certifice funeral director, r To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO059973 nsun D Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Cambridge Johnson Street Bramble 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 2 2005 Registrar

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			jiene leg. No. 20 (	)5	28211	
5	Physici /Medi		1. Decedent's Name (First, Middle, Last	ZARELL	-0			2. Date of Dea Month	th Day Y	ear	3. Time of Death 4:50 PM	
	Examir		4a. Fecility Name (If not institution, give  NORTHWEST HO  5. Social Security Number 6. Se	SPITAL C	-	LLS TO U	200					
	Funeral Director		,	DM 2□F	88 Yrs.	Months Days	Hours Mi	1. (Month, Day	, Year) ), 1916		ace (State or Foreign ry) Cyland	
	he Marylan 8a-f show ctimed at	Director	MD Baltin	nore	10c. City, Town or L	Reisters	town				d. Inside City Limits 1 ☐ Yes 2 🖾 No	
	eath with ti na 23a or 2 must be n	Funeral Dire	10e. Street and Number  114 Sacred H  11. Marital Status	eart Lane	ver in U.S. 13		136		U.S.	Α		
980	ours after deat ral', or Itema Evac, iter ma	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Specify Yes or No- rto Rican, etc.)	Black,	White, e	tc.	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itema 23e or 28e-f show event, the Medical Eratin or trivial terrolling at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e <i>completed)</i> College (1-4or 5-	(Give	dent's Usual Occup skind of work done DO NOT use retired Brick Lay	during most of w d)	orking	16b. Kind of Busi		•	
77	be filed ital Hygi id other	To Be Co	17. Father's Name (First, Middle, Last)  Joseph Azzar	ello		BIICK LAY	18. Mother's N	ame (First, Middle,		ucti	LON	
Mary			19a. Informant's Name/Relationship (T)	, ,			and Number or I	Rural Route Number			,	
Je,	m 0 .		Marie J. Azzarello  20a Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ F  1 ☑ Donation 5 □ Other (Specify)		20b. Place of Disp	osition (Name of matory or other plac	oe)		20c. Location - Ci	ty or Tow		
Baltii	permit, Page Department of Important: If any injury or once.		21. Signature of Fundard Service Licens	el.	2	2. Name and Addre	ss of Facility 1	1824 Reis E Reister	terstown	Roa	ıd	
	nysician		23a. Part 1. Enter to disbase, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	-	the death. Do not en	ter the mode of dyin	ng, such as cardi	ac or respiratory arr	est,		Approximate Interval Between Onset and Death	
	/Medical Examiner	J.	J.	resulting in death)  Sequentially list conditions,	CHOL	consequence of):	TIS					
8760,	e be executed sician and surial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. First at the bertying. Cause (Disease or injury that initiated events resulting in death) Last	ō	consequence of):							
O. BOX 68	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medle	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t3c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of Month		y Day Year	
rds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions co	ntributing to death but		inderlying cause giv	en in Part I.		bacco use contrib es 2 □ No 3	ute to the	1.0	
		Completed						24a. Was a autops perform	sy prio mad2 dea	re autoporto com ath? Yes 2	sy findings available pletion of cause of 2 No	
	ding Physician. J. After this certific tuneral director.	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manger of Death 1 Natural 5 Pending investigation	Hospital: 1 Anpatien 28a. Date of Injury (Month, Day		f 28c. Injun Wor	er: 4 ☐ Nursing	eath (Check only or Home 5 Reside 28d. Describe ho				
DIVISION	al or Attending s frer death, al Cirector: After ad in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (Si City or Town	treet and Number n, State)	or Rural	Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in I	Medical	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of a and manner state	examination and/or in	vestigation, in my o	pinion, death occ	curred at the time, d	ate and place, and	d due to t	the cause(s)	
,	To t To t	M	29b. Signature and the of certifier			29c. Licens <b>D</b> 42	723	A	9d. Date signed (	7	2005	
	10		30. Name an address of person who co			9401	HWES	T HOS	TROP	S.	ENTER M Dall33	
	Sta Registi		31. Date filed (Month, Day, YAUG 3	0 2005 Begistrat	Signature	Sparte						

State of Maryland / Department of Health and Mental Hygiene 2005 28215 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2005 ear August 23 Crescentia 4:00 P M Azzaro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie 107 Janelin Drive Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-10-1907 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 217-56-7735 98 Director Usual Residence of Decedent death with the Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "neturel", or Items 23a or 28a-f shov The Medical Examinar must be notified at 1 ☐ Yes 2√ No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 107 Janelin Drive 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Item any injury or other traumatic event, the Medical Exempted 2008. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2\OXNo Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis Bacigalupa Angela Louise Cuneo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carmella Kupfer/daughter 107 Janelin Drive, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cem. 8/27/2005 Baltimore, MD al Service Lic see 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signal 401411 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1220 10 /Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 1 Tes page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has ormed? 2 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) 2 Hospital: 1 Inpatient Cther: 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) 2 1 🗌 Yes 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) 101 ss of person who completed cause of death (Item 23a) (Type, Print) 280 HUDSON 32. Registrar's Signatu 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28216 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** vonne 25, 7:00 A M August 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5-17-1928 Birthplace (State or Foreign Country)
 NC **Funeral** Hours 1 ☐ M 2 🔼 F Director 241-36-6810 77 Yrs. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23s or 28s-f show the Medical Examiner must be notified at by Funeral Director 1 ☐ Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7969 Quail Court 21061 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: t Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Itam 27 is marked ott jury or other traumatic avan Willie B. Knowles Mattie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Susan M. Cox / Daughter 2134 Cox Road, Gambrills, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any injury or soce. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation | 8-27-2005 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. NO135 Tark 1 Second Ave S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) duone renul failure **Physician** 1045 - Mon /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attanding Physician: The law requires thet the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physicien Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No this certificete 2□ No 1 ☐ Yes 1 Tes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury s after dec. 5 Pending 1 TYes 2 TNo 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date/signed (Month, Day, Year) when 057078 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway, Runagolu Medical Jack welme 2001 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 28217 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** James Anderson August 20, 2005 2:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1₩ 2□F Director 83 215-16-1378 Jan 6, 1922 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at MD 1 ☐ Yes 2 ☑ No Funeral Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 303 Pine Forest Court 21093 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "netural", or iteme 11. Marital Status Amed Forces:

1 GYes 2 No
If Yes, Give
Year or Dates: 42-45 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens important: if item 27 ie marked other tha any jury or other traumatic event, the 2005. 12 salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James V. Anderson Sr Daisey Evelyn Vernelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Marie Anderson/spouse 303 Pine Forest Court Timonium, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Si nature de meral Service icensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Melanoma me tastatic Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10061199 Aug. 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Black

AUG 3 0 2005

Jason

31. Date filed (Month, Day, Year)

6601

2. Registrar's Signature

Division of Vital Records, P.O. Box 68760

North Charles Street, lowson MD

			1 - For State Registrar	State of Ma	aryland / [	Departi <i>Certifi</i>	ment of F	lealth and Death	Mental Hy	giene Reg. No.		28218
Ì	Physici /Medio	al	Decedent's Name (First, Middle, La     Mildred But:     4a. Facility Name (If not institution, give	ler		Ab	City Town o	r Location of Dea	2. Date of De Month 0 7	Day 2.7		
	Examir Funeral Director	er	Southern Mai 5. Social Security Number 6. S 579-32-8302	cyland Ho	e (In yrs. last bir	thday) If	Clin	ton	s. 8. Date of Bir	Pr th ay, Year)	gince G	George's  pplace (State or Foreign intry)
	s filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or items 23a or 28e-f show rant, Tre Predical Eventral Frankles at a rant, Tre Predical Eventral Frankles at a rank.	Director	Usual Residence of Decedent  10a. State 10b. County  DC  10e. Street and Number  171 35th Street	Pet N E	10c. City, Tow	shin	gton of. Zip Code	019			zen of What Cou	10d. Inside City Limits  12€ Yes 2 No  untry?
036	ours after death ral', or items 23 Examinatinus	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2€11 If Yes, Give Year or Dates:					Specify Yes or Norto Rican, etc.)	D-	ed Sta  14. Race - Amer Black, White  Specify: B1	ican fndian, , etc.
9500-61212	ed within 72 ho ygiene. nar than "natur t, the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ade completed) College (1-4or 5		(Give kind life. DO l	s Usual Occup l of work done o NOT use retired Le Make	during most of wo		D	nd of Business/I	,
ryland	be d ave	To Be	17. Father's Name (First, Middle, Last, Christopher (  19a. Informant's Name/Relationship (	Columbus			ddross (Stroot	There	esa Bari	nes		
saitimore, Mar	permit. Pages 1 and 2 should Department of Health and Mer Important: If itam 27 is marke any njury or other traumatic once.		Melodie L. Fer  20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other (Special 2). Signature of Funeral Service Lice	NWich Removal from State (y)	20b. Place or cemeter.	46 H f Dispositionly, cremato	amilton (Name of ry or other place	on Plac	Date	20c. Lo	ldorf,	MD 20602 Town, State
J	Physician /Medical Examiner		23a. hart1. En er the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir a. <u>Hypert</u> Due to (or as	the death. Do ne.  ensive a consequence	Latenot enter the Car	ney's e mode of dyin diovas	F'unera g, such as cardia	1 Home	rest,	ash.,	Approximate Interval Between Onset and Death
8/60,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Hypert	ension	of): L of):		ciency				
O. Box 62	at the death certificate I by the attending phy stached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		opic pregnancy ner (specify)			2	23d. Date of deliv Month	very Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of Diabetes Mell		ut not resulting in	the under	lying cause give	en in Part I.				the cause of death?
al Kecord	The law ate has b page 2 sl	Completed	Chronic Edema Dehydration	of lowe	r extr	emit	ies		24a. Was auto perio 1  Yes		24b. Were aut prior to codeath?	opsy findings available ompletion of cause of 2 No
on or vital	ling Phy I. After this funeral d	ion: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒No  27. Manner of Death  1 ☒Natural 5 ☐ Pending	Hospital: 1 Inpatie	ry. 28b. 1	Time of njury	28c. Injun	er: 4 Nursing	ath (Check only of Home 5 Residue) 28d. Describe	dence 6		ify)
DIVISION	or Attan Ifter deal Diractor: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Injubuilding, etc	c. (Specify)	ırm, street,	factory, office	Yes 2 □No	City or To	wn, State)		ral Route Number,
	24 h	edical	one)	nysicien: To the best of miner: On the basis of and manner sta	examination an	e, death occ d/or investi	gation, in my of	oinion, death occ	e, and due to the urred at the time,	date and	place, and due	to the cause(s)
	To the within To the compl	Σ	29b. Signature and title of certifier	woffers	(D)	12	D44				e signed (Month,	
1	) `		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, Print	1)					- 00511

State Registrar

Jonathan Thompson, MD

3 Registrar's Signature

7111 Allentown Road, Suite 101; Fort Washington, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $2\,0\,0\,5$ For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) U'.56PM **Physician** 2005 Boyd Jr. 14042 Eugene William /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Jenero 5. Social Security Number If Under 24 Hrs. If Unde 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex last birthday **Funeral** Days Hours Min 1**√**M 2□F 40 Vrs MD Director 220-76-2706 06 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show other traumatic avent, the Madical Examiner must be notified at 1XYes 2 □No Baltimore Director NA 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. ftems 23a 21217 Completed by Funeral 1433 Angyle Ave Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2 Married ŏ 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Distributors na Warehouseman llth grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gladys Knight ဂ္ William E. Boyd Sr. wyes 1 and 2 showed to the shift and he important: if Item 27 is many injury or other any injury or other and injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21215 205, Balto, 4601 W. Northern Pkwy Apt Gladys Boyd-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/31/05 Baltimore, Md Voshells 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H West 21215 Thom 4300 Wabash Ave, Baltimore, Md 23a. Part Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final O **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be del ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes \_ 2**∑** No : After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation al or Attend after death | Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide To the Hospital o within 24 hours af To the Funeral Di To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DR. CHANCHAL SINCH, M.D.D. 30. Name and address of person who completed cause of death (Item 23a) (Type

DHMH 17 Rev 1/2001

State

Registra

31. Date filed (Month, Day, Year) AUG 3 0 20

0 2005

aparte.

DINGIN

62. Registrar's Signature

		-	For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of H rtificate of L			ene 3. No 2005	28220
			Decedent's Name (First, Midd	lle, Last)				2. Date of Death		3. Time of Death
	Physicia	_	micha	e-/ A	BALL			AUGUST	23 2005	- 11:15 PM
	/Medic Examin	-	4a. Facility Name (If not institution	on, give street and numb		4b. City, Town, or	Location of Deat		4c. County of Dea	ith
0	LXamin	CI	2601 Madison	Avenue		Balto			N/A	
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs		9. Bi	thplace (State or Foreign ountry)
	Director		212-44-8923	1 <b>X</b> M 2□F	58 yrs.	Months Days	Hours Min.	6-3-19		Md
	D		Usuel Residence of Decedent							Transfer or transfer
	nylan	_	10a. State 10b. Count	•	10c. City, Town or L	ocation				10d. Inside City Limits 14 Yes 2 ☐ No
	e Ma	to to	Ma	N/A	Balto					
	ih th	Olre	10e. Street and Number			10f. Zip Code 2121	7	10	g. Citizen of What C USA	ountry?
	23a	Funeral Director	2601 Madison							
	r dez	ne	11. Marital Status	Amed Ford	es?	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
36	72 hours after death with the Maryland naturel', or items 23a or 28e-f show Jisal Exam for must be notified at	ΥF	1 Never Married 2 Ma	If Yes, Give	! □ No	1 ☐ Yes 2√ No	Specify:		Specify:	Black
Ö	ural'	Completed by	3 ☐ Widowed 4 ☐ Divorce			edent's Usual Occupa	ation	1.	6b. Kind of Busines:	
7	nat	lete	(Specify only high	nt's Education est grade completed)	(Giv	e kind of work done of DO NOT use retired	during most of wo	rking		
12	within lene. than	E D	Elementary/Secondary (0-12)	College (1-	4or 5+)	aborer	,		Various	Jobs
2	filed Hygid Sther		17. Father's Name (First, Middle	. Last)	N/A La	aborer	18. Mother's Na	me (First, Middle, M	a <i>iden Sur</i> name)	
Maryland 21215-0036		o Be	James Armste	ad Ball			Doris N.	Peters		
7	should be nd Mental markad c	၉	19a. Informant's Name/Relation	iship (Type, Print)	19b. Mail			ural Route Number,	City or Town, State,	Zip Code)
Z	d 2 s		Deborah Ball							Md 21228
ē	1 and Health tem 27		20a. Method of Disposition	- Sister_	20b. Place of Disp	- 11 A SANS		4	0c. Location - City o	
2	00		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		tate	n Forest V		2005	Owings Mi	11a Md
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service		The state of the s	22. Name and Addres	Total III		F/H West	LIIS, Mu
Ba	permit. Pag Department Importent: I eny injury o		3/10	21	0	43	00 Waba	ash Avenue	•	(d. 21215
			23a. Pert1. Enter the disease,	or complications that ca	used the death. Do not er					Approximate
			shock, or heart failure. List Immediate Cause (Final	st only one cause on ea	ch line.					Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Due to	r as a consequence of):	7				
н	Examiner			Due to (	e as a consequence or.					
		- E	Sequentially list conditions, if any, leading to immediate	b. Due to (o	or as a consequence of):					
V	nted Insit	Ë	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	* HI	1405					
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (o	or as a consequence of):	)				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		a_ch	rance Kic	mey ()	sease			
.89	ificati g phy as the	edic								
Box	Jeath certifica attending phate of tor use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy				23d. Date of d	7
	that the death cer ed by the attendir detached for use	<u>c</u>	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregna	int at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
0	t the o	hys	9 Donknown	9□ Unknov	wn /					
۳.	w requires that s been signed t should be det	y P	Part II. Other significant condi	tions contributing to dea	ath but not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ž	quire on sig uld b	pe L	<u>Substance</u>	Abse	Depres	sim, Pa	5.7	1 ☐ Yes	s 2□No 3□F	Probably 4 Unknown
Records,	s bee	Completed by	Howmake	Stress	- 0000	slen 1	Jepahis (	24a. Was an autopsy		autopsy findings available completion of cause of
200	The la	E	Don't a	200 -	con-alian	_00		perform	ed? death?	
Vital	en: tiffica tor, p	0	25. Was case referred to medic	cal	are picer-		26. Place of De	ath (Check only one		
-	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ In	patient 2 ER/Outpati	ent 3 DOA Oth	er: 4 🗌 Nursing I	Home 5 esider	nce 6 Other (Sp	ecify)
So uo	ig Ph terth heral	ü	27. Manner of Death	28a. Date o	f Injury 28b. Time	of 28c. Injur Wor	y at k?	28d. Describe how	w injury occurred	
70	ath. r: Af	atlo		stigation \	MA NI	→ M 1□	Yes 2 Hale		NIA	
). Se	er de racto by th	tific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 200. Flace	of Injury - At home, farm, ing, etc. (Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or I State)	Rural Route Number,
<sup>2</sup> ≥	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Certification;			2	M		11	NIIT	
	tosbi t hon uner	edical	29a. Certifier (Check only 2 Medic	ring Physicien: To the el Examiner: On the ba	best of my knowledge, deasis of examination and/or	ath occurred at the tin	ne, date and plac pinion, death occ	e, and due to the ca- turred at the time, da	use(s) and manner a te and place, and di	as stated. ue to the cause(s)
	the F in 24 the F iplete	edi	one)	and mann					d. Date signed (Mor	
	With To	Σ	29b. Signature and title of ce ti	lie /	) _ 01	29c. Licens	e tinitioal	29	o. Date signed (Moi	Jay, rear)
,			and	- Con		cia mo	055656	0	8/29	0)
	mx1		30. Name and address of person	on who completed cause		e, Print)	R-1	62.08	MAD -	2/201
	")		125 W.	Lan >0-0	( Street	PISE	1200	nanc	IVV I	(201
		ate	31. Date filed (Month, Day, Yea AUG 3	0 2005 32.00	egistrar's Signature	castes				
	Regist	rar	7000	0 2000	merca se la					

	1	1 - State of Maryland / Department of Health and Mer Certificate of Death	ntal Hygier	2005	28221
Physicia	n	DOSA	. Date of Death	Day Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give street and number)  Bon Secours Hospital  4b. City, Town, or Location of Death  Balto		4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	(Month, Day, Yea	ar) 9. Birthp Cour	place (State or Foreign htry) W. Va
Manyland f show	٥.	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location           Md         N/A         Balto		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the Na or 28e-	Director	10e. Street and Number  2920 Woodland Avenue  21215		Citizen of What Cour	itry?
	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Ric		U S A  14. Race - Americ Black, White, Specify: B:	
within 72 hou lene. Than "natura If a Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12th grade  15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker	16b.	Kind of Business/Ind	dustry
Mal y latter A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A	10 Be C	17. Father's Name (First, Middle, Last)		len Sumame)	
and 2 shoutealth and N m 27 is main har traumai	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural R	Route Number, Cit 1 <b>to</b> , Md		Code)
Page nent o		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Garrison Forest Vet 8-31-2		Location - City or To	
permit. Departmitimports any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Ma  4300 Wabash Av	rch F/H enue Ba	West lto, Md 2	1215
Physician /Medical		23a. Part. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or resulting the cause (Final disease or condition resulting in death)  13a. ATHEROSCLEROTIC COROWARY ARTS  15b. Due to (or as a consequence of):		FASE	Approximate Interval Between Onset and Death
ate be executed minimum and hysician and the burial-transit	dicai Examiner	Sequentially list conditions,			
death certific e attending p of for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown		23d. Date of delive	ary Day Year
w requires that the speed of th	ğ	Part in Other significant contributing to death but not resulting in the underlying cause given in Part i.	23e. Did tobacc	co use contribute to the	
has has	Completed		24a. Was an autopsy performed	prior to condeath?	psy findings available mpletion of cause of
Physician: Physician: rthis certific ral director,	To Be	examiner?  1   Yes   2   No			v)
DIVISIO DI or Attendi s after death i Diractor: A d in by the fu	ertification:		f. Location (Street City or Town, St	and Number or Rura ate)	I Route Number,
ha Hospi in 24 hou ha Funar pletely fill	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and control of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
To ti withi To ti	Ž		29d. (	Date signed (Month,	Day, Year)
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  EDWARD BOLGIAND MD ZOOO W BALTIME	ORF 5	7 3	1223
Stat Registra	e Ir	31. Date filed (Month, Day, Year) AUG 3 0 2005 AUG 3 0 2005			

State of Maryland / Department of Health and Mental Hygiens 28222 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** BENEDICT 3:00 PM ROBERT ARTHUR AUGUST 22 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL NORTHWEST Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 13,1924 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F YES Dec. MD Director 212-20-4247 80 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic avent, the Modeal Example must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Owings Mills Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9007 Groffsmill Drive 21117 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Mayes 2 ⊡ No If Yes, Give Year or Dates: T 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White þ 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) W. L. Reynolds Co. <u>Sales Manager</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fullen Orville W. Benedict Carmelite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 9007 Groffsmill Road Owings Mills, MD 21117 Mrs. Adele M. Benedict 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 8/26/05 Hampstead, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD lui a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shick, or heart failure. List only one cause on each line Onset and Death Immed ate Cause disease or condition resulting in death) mediate Cause (Final LUNG Physician CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Ves 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 1 mpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Diractor: A 2 Accident investigation the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 AUGUST 25 2005 TODOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCEA NORTHWEST tos PITAL 5401 OLD COURTROAD RANDALLSTOUN 31. Date filed (Month, Day, Year) 32. Registraça Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 90528223 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Alice G. Burgan August 25, 2005 9:50 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Charlestown Retirement Center Catonsville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
July 22, 1 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 K F Yrs. Director 212-38-0537 91 1914 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show or Itams 23a or 28a-f shov **Funeral Director** Catonsville 1 ☐ Yes 2X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 719 Maiden Choice Lane BR 508 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Eventuer Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is markad othar than "natural", or Ital 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Morris J. Gardner Mary Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter J. Burgan 719 Maiden Choice Lane BR508 Catonsville, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department o Important: If any Injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 18/29/05 Pikesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD Eline Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death Year 5 Other (specify) the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, armens discore 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 280 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes after death.

Director: After this certifical in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier-29d. Date signed (Month, Day, Year) 0 00020000 26 Ancie Cane 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), any (( alden 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2005 Registrar

			1 - For State Registrar	State of Maryland /	Department of I	Health and M	ental Hygie	•	28224
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Las     Horace Edward Bur      As. Fecility Name (If not institution, give	ton, Sr.	4b. City, Town,	or Location of Death	2. Date of Death Month August 2	Day Year  0, 2005  4c. County of Death	3. Time of Death
	Funeral Director		1400 Drexe1 Stree  5. Social Security Number 221-05-2869  Usual Residence of Decedent		Takoma P irithday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye Oct. 23,	Prince Geo 9. Birth Cou 1923 Dela	orge 's place (State or Foreign intry) aware
	72 hours atter death with the Maryland Instural, or Items 23a or 28a-f show digal Examinar mual os notified at	ector	NJ Atlant		wn or Location Harbor Towns	hip			10d. Inside City Limits Yes 2 □ No
	sath with ti s 23a or 2 nual be o	erai Dire	10e. Street and Number 3008 Ivins Avenue		10f. Zip Code 082		U	Citizen of What Cou	tes
920	ours after de ral', or Item Examinar i	by Fune	11. Marital Status 1 □ Never Married 2√□ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ™ Yes 2 No If Yes, Give Year or Dates: WW I I	13. Was Decedent of I If Yes, specify Cub		city Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hydiene. Department of Heath and Mental Hydiene. Important: If them 27 is marked other than "natural; or liems 23a or 28a-1 show any injury or other traumatic event, the Medical Exam nor must be notified at ance.	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Clergy/Pas	during most of workii d)	ng	o. Kind of Business/In	dustry
Maryland 2	12 should be filed within hand Mental Hygiene. 7 Is marked other than "r traumatic event, the Med	To Be Co	17. Father's Name (First, Middle, Last) Frederick Douglas		<u> </u>	18. Mother's Name Bessie	(First, Middle, Main	den Sumame) Wart	
a)	1 and 2 sho Health and tem 27 Is m		19a. Informant's Name/Relationship (7  Margaret Burton/ S  20a. Method of Disposition	Spouse 20b, Place	b. Mailing Address (Street 3008 Ivins A of Disposition (Name of	venue Egg	Harbor To		IJ 08234
Baltimore,	permit. Pages Department of I Important: If Ite any injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service bicens	Delawa	ery, crematory or other pla are Vets Cem 1 22. Name and Addre	etery 8-2	9-05 B	ear, Delaw	are
	Physician		23a. Part1. Enter ye ise st. or comp shock, or h an ailura List only of Immediate Cause (Final disease or condition	lications that caused the death. Do no cause on each line.	Greenidge / 301 Abseco	n Blvd A	tlantic	City, New_	08401 Jersey Approximate Interval Between Onset and Death
	taw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ledicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Character of the cause is the condition of the cause is the cause of the cause is the cause of the cause is the cause of th	b. — Due to (or as a consequence c. — Due to (or as a consequence d. — Due to (or as a consequence	e of):				
.O. Box 6	that the death certification by the attending place detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnanc 5 Other (specify)	у		23d. Date of delive Month	ery Day Year
Records, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ntributing to death but not resulting	in the underlying cause gr	ven in Part I.		co use contribute to the	he cause of death?
<u> </u>	The ate h page	Completed	OF Wassesseless and a section				24a. Was an autopsy performed 1 Yes 2X	? prior to co	ppsy findings available mpletion of cause of 2 No
	ding Ph h. After th tuneral	ation; To Be	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 EP/C  28a. Date of Injury (Month, Day Year)  28b.	Time of 28c. Injury Wor				yDaughter's
É	i gitt o	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)			City or Town, Si		
	To the Hospital within 24 hours of To the Funerel completely filled	Medical	one)	rsician: To the best of my knowledginer: On the basis of examination a and manner stated.	nd/or investigation, in my o	pinion, death occurre	d at the time, date	and place, and due to	the cause(s)
)	wit Cor		29b Signature and title of certifier	Meltzu.		3743		Bust 20, 2	
10	)		Martin Weltz, MD	7525 Greenway		, #205, Gr	eenbelt,	MD 20707	
	Sta Registi	- 611	31. Date filed (Month, Day, Year)  AUG 3	32. Registrar's Signature	16 Coastes	7			

DHMH 17 Rev 1/2001

ORIGINAL

	-		For State Registrer americal item.  1. Decedent's Name (First, Middle, Las	State of Ma	ryland	d / Depa <b>7 <i>9</i>/</b> 0	artment 1/65	of H	ealth a Death	ind M		Reg. No.		5	282	
Phy	sicia	n	Lucille F. Bjar	200							Month	Day	20°	er O5	5:30	
	edica mine		4a. Facility Name (If not institution, give				4b. City, T	own, or	Location of	f Death	August		County of		7:30	
Exa	mme	:11	Edenwald Retiremen		·V		Tow						Balti		۵	
Fune	ral		5. Social Security Number 6. Se	x 7. Age	(In yrs. la	ast birthday)	If Under 1	1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir			Birtho	ece (State or	Foreign
Direc			056-09-8986	□M 2 <b>X</b> )F	9	)3 Yrs.	MORENS	Days	Hours	MINI.	8. Date of Bir Sept 2.	9,191	11	Nev	York	
pug *		-	Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	ocation							1	0d. Inside City	/ Limits
faryle		5	Maryland Baltimo		Too. Oily,	Tows								"	1 🗆 Yes	
the N 28a-1		ect	10e. Street and Number			10%3	10f. Zip (	Code				10a. Citi	zen of Wha	nt Coun	try?	
with 3s or		Funeral Directo	800 Southerly Roa	d					286				USA		,.	
death ms 2		nera	11. Marital Status	12. Was Decedent Ev	ver in U.S	6. 13.	Was Decede			gin? (Spe	cify Yes or No Rican, etc.)	- ]	14. Race -			
after or Ite			1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ️XNo	)		ır res,speci 1 □ Yes 2		Specify:	, Риепо і	rican, etc.)	}	Black, \	white, o Whi		
nours arait,		d by	Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:									Specify:			
II 6 12-10-0050  (iled within 72 hours after death with the Maryland Hygiene Hygiene 11 instural, or Items 23s or 28s-1 show with restricted to the second of the second o		Completed	15. Decedent's Ed (Specify only highest grad			(Give	dent's Usual kind of work DO NOT use	k done di	uring most	of workir	ng	16b. Kii	nd of Busin	ess/Inc	lustry	- 1
d withi		E O	Elementary/Secondary (0-12)	College (1-4or 5+	)		inistr	,		ssis	tant		Oil (	Comr	anv	
Hyg other		a l	17. Father's Name (First, Middle, Last)								(First, Middle	, Maiden	Sumame)		, arry	_
should be fill and Mental His smarked oth		9 P	Anthony Fischer					-		Els	ie S <del>eel</del>	KOPP				
ire, Marylating ZIZIO-0030  s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item ZY is marked other than "natural", or Items 23a or 28a-1 show they teams in Standard the Theology.			19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a	nd Number	r or Rura	Route Numb	er, City or	r Town, Sta	te, Zip	Code)	
is 1 and 2 of Health a litem 27 is		-	John Sabatelli, S	on	1				ourt (		nsville					
Pages 1 nent of H	5		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □	Removal from State	Ce	metery, crei	matory`or ott	her place			ate		cation Cit			
Dallimor Department of Mportant: If it	1		* 4 □Donation *5 □ Other (Specify		Met	ro Cr		•	,					,	Maryla	
permit. Pages 1 an Department of Heal Important: If Item 2	Suce		21. Signature of Funeral Service Upon Thomas Gregor	7		Š	remati 99 Fre	on der	Societ ick l	ty 0 Road	f Maryl Baltin	land, nore,	Inc. Mary	lar	d 2122	.8
	₹.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused to one cause on each line	he death. ).	. Do not ent	er the mode	of dying	, such as c	cardiac o	r respiratory a	rrest,			Approximate Interval Betwo Onset and De	een
Physici	_		Immediate Cause (Final disease or condition resulting in death)	a. Fno	120	1 51-	-171	Α							104	nı
/Medio				Due to (or as a	consequ	ence of):	676								,	•
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequ	ence of):					_			-		
uted	5	Examiner	cause. Enter Underlying Cause (Director of Injury) that initiated events	C												
O, exec an an	3		resulting in death) Last	Due to (or as a	consequ	ence of):					-					
wrequires that the death certificate be executed been signed by the attending physician and about he death of the physician and the physic		edicai		d												
OX of the control of			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2			70-1					2	3d. Date of	f delive	гу	
death be atter		Physician/M	in the past 12 months?	4 Pregnant at ti			⊒Ectopic pre ☑ Other (spe						Month		Day Ye	9ar
law requires that the as been signed by the school of the defends		Phy	9 Unknown								00- 8:44					
res th	2	ğ	Part II. Other significant conditions co	intributing to death but	not resul	iting in the u	nderlying ca	use give	n in Part I.		238. Dia 1	/ _		te to th ] Proba	e cause of de ably 4 ⊟Un	
w requires been sign		Completed									7					
1) 8 80		mp									24a. Was autor			r to con	sy findings av	
VII.dI IN Ician: The Pertificate ha	1	ပိ	25. Was case referred to medical								1 Yes	2 No	10		2 No	
OI VILA Physician: rthis certific		o Be	examiner?	Hospital:	2 🗆	R/Outpatier	nt 3 🗆 DOA	Otho			(Check only only one 5 ☐ Residue)		DOther /	Cassifi	1	
ding Phys	8	⊢ ⊦	27. Manner of Death	28a. Date of Injury	200	28b. Time of		c. Injury Work		-	8d. Describe			<i>эреспу</i>	/	
Attending at death.		atio	1 XNatural 5 Pending 2 Accident investigation	(Month, Day	rear)	Injury	м		? ′es 2 □ N	No						
r Atte	5	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At hor (Specify)	me, farm, str	eet, factory,	office		2	8f. Location (3 City or Tox			r Aurai	Route Numb	er,
To the Hospital or Attending Physician: within 24 hours elter death.  To the Funeral Director. After this certific monolate tilled in white funeral director.	8	C	29a. Certifier X Certifying Physics	vsicien: To the best of	my know	vledge, deat	h occurred a	it the time	e, date and	d place, a	nd due to the	cause(s)	and manne	er as sta	ated.	
in 24 l	999	edic	one)	iner: On the basis of e and manner state	ed.											
with To t	3	Σ	29b. Signature and title of certifier	)			29c.	License	number	20		29d. Date	e signed (N	fonth, L	Day, Year)	
	2		ppu 13	rance			,	, ,	18	28		TUC	USI	70	1, 200	15
1	U		30. Name and address of person who c	ompleted cause of dea	ath (Item	23a) (Type,	Print)	300	72.4	Ron	m' L	101	12m	1	109	2
	Stat	е	31. Date filed (Month, Pay Year)	200 32. Registrar	's Signati	ure	Coarte.	0	1/1:1			, ,	1 11		', V	
	istra	-	11000			- /										

·563	30		State of Maryland / Department of Heal 1- State Amend Item 1&28f per me G846 8-30-05 tas Certificate of Dea	th and Mental I a <i>th</i>	Hygiene 2	005	28226
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death Day	Yeer	3. Time of Death
1	/Medic	al	Richard Paul Boroughs  4a. Facility Name (If not institution, give street and number)  4b. City. Town. or Loca	AUGUS		2005 unty of Death	0340 A M
	Examin	er	JOHNS HOPKINS HOSPITAL BALTIMORE			N/A	(0)
	Funeral Director			ours Min. 8. Date of (Month, June)	Day, Year) 14, 198	Coun	ace (State or Foreign try) Yland
	yland		10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
	e Mar infied	ctor	Maryland N/A Baltimore				1 Yes 2 □ No
	death with the Maryland me 23a or 28a-f ehow rouat be notified at	Funeral Director	10e. Street and Number 411 S. Collington Avenue  10f. Zip Code 21	231		of What Coun	try?
5-0036	ages 1 and 2 should be filed within 72 hours after death with the Marylan ni of Health and Mental Hygiene.  If Item 27 Is marked other then "neturel", or Iteme 23a or 28a-1 show or other treumatic event. In Medical Extendible mark to notified at	þ	11. Marital Status  1	ic Origin? (Specify Yes or exican, Puerto Rican, etc.) ecify:		Race - Americ Black, White, ecity: Whi	etc.
5-0	72 h	etec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind	of Business/Inc	lustry
2121	ed within ygiene. ver then t. Ibe Me	Be Completed	12th Grade  College (1-4or 5+) Bar Back			aurant	
and	ntal H ed oth	Be		Mother's Name (First, Mid Emelie Flo		,	
Maryland	should nd Me n mark imatic	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N				Code)
Z,	and 2 alth a n 27 le	j	Mrs. Emelie Boroughs (mother) 62 Stone Park Pl	Pace, Nottin	gham, M	D 21236	
Baitimore,	permit. Peges 1 and 2 Department of Health a Important: If Item 27 It eny Injury or other tre		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ion - City or To	
III.	it. Per rtant: nlury		4 Donation 5 Other (Specify)  St. Michael Luth. Ch  21. Signature of Funeral Service Licensee				
Ba	permi Depa Impo eny Ir		21. Signature of Funeral Service Licensee 22. Name and Address of F 9705 Belair				8
	Physician /Medical Examiner	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heert failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):  Due to (or as a consequence of):		y arrest,		Approximate Interval Batween Onset and Death
8760, P	icate be executed physicien end s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
P.O. Box 6	w requires thet the death certifi been signed by the attending t should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d	. Date of delive Month	ry Day Year
ds, P.	uires thet signed by Id be deta	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F		id tobacco use		e cause of death?
Vital Records,		olete		24a. W		4b. Were autor	sy findings available
Re	hysicien: The law his certilicete hes t il director, pege 2 s	mo		1 X Ye	utopsy erformed? s 2 □ No	death?	pletion of cause of
/ita	Physicien: this certific ral director,	Be	examiner?	Place of Death (Check on	ly one)		
of \	Physi this c	<u>۲</u>		Nursing Home 5 R			)
Division of	nding lith. ; After e funer	Certification;	27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of Injury 3  202  M 1  Yes		i refshir	L	
Visi	Atter ector by the	Iffica	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f Locatio	n (Street and N Town, <b>State) 1</b>	umber or Rurai	Route Number,
Ö	ital or irs afte ral Dir led in	Cer	At home	411 Sout	4 Chinto	n St. Da	Himsel, HD
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, da 2☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	ite and place, and due to to i, death occurred at the tin	he cause(s) and ne, date and pla	d manner as sta ice, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License num	nber	29d. Date si	gned (Month, L	Day, Year)
			> Zabrilled Ahr OCME		AUGUST	20, 2	2005
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ZARIUCIAH ALI 111 PENN STREET,	BALTIMORE,	MARYLAN	ID, 2120	)1
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DH	Registr MH 17 Rev 1/2		AUG 3 0 2005 January 15 Grantes		·		

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 28227 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician**  $P^{M}$ 7:18 August 25 2005 /Medical Henry L. Butta
4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale 8317 Analee Avenue If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral X**XM 2□ F Months August 15, 1921 Director 84 Maryland 214-16-86<u>21</u> Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28e-1 show the Medical Examiner must be nutitive at 1 ☐ Yes 2√∑ No Baltimore Rosedale Director Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 8317 Analee Avenue 21237 United States or Items 23a death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑DYes 2 □ No If Yes, Give Year or Dates: WWI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced WWII White "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Electrical Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other treumatic event 2008. Be 2 John Butta Virginia Cherigo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8317 Analee Avenue, Baltimore, Maryland 21237 Dolores Butta-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 08/29/2005 Baltimore, Maryland Gardens of Faith 22. Name and Address of Facility 21. Signature of Funeral Service Lio see David J. Weber Funeral Homes, P.A. Me 401 S. Chester St. Baltimore, Maryland 21231 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metrica Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to uninediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consustrence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No be detached Division of Vital Records, P.O. the 9 Unknown 9 ☐ Unknown þ 23e. Did tobacco use contribute to the cause of death? peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed page 2 certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospitel 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hiladelphia Rd Suite208 21237 AN 15/1K9n 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/200

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
PII State of Maryland / Department of Health and Mental Hygiene 005 28228 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer BANKS, **Physician** TREGORY 4:58 PM HNTHONY 18th 2005 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Good Samositan hospital Baltimore 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 100 M 2□ F 60.5375 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10a. State 10c. City Town or Location 28a-f show other traumatic event, the Medical Examiner must be nightlied at 1 Yes 2 □ No BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number ō U.S.A iteme 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Aispanic Origin? (Specify Yes or No-If Yes, specify Caban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 0 ACK Baltimore, Maryland 21215-0036 2 No Completed by 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last, 's Name (First, Middle, Maide Be BERNICE 19b. Mailing Address (Street and Number or Rusal Route Number, City 19a. Informant's Name/Relationship
DENISE BANK 2904 NE. permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other trau once. 20b. Place of Disposition cemetery, cremator Date 20a. Method of Disposition 1 Burial 2 Cremation 8-24-05 3 Removal from State GREEN MOUNT ( 4 ☐ Donation 5 ☐ Other (Specify) REMATORI C. GREENE FUNELARTHM Name and Address of Facility V AVEHIV 21. Signature of Funeral Service Licenses KOHV Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stroke Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Coudio myopatt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Chronic Narcotism Examiner The it wirequires that the death certificate be executed CAL EXAMINER that initiated events CERTIFICATI X PPRO resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown Ö 9 Unknown igned by م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hais autopsy performed ours after death.

leral Director: After this certificate I filled in by the funeral director, page Hypertension 1 Yes 2 **W**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 🗹 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 201 2 ER/Outpatient 3 DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. ŝ 29d. Date signed (Month, Day, Year) 29b. Signature and Me of certified 29c. License number MD Kunnille Res 000 August 18th 2005 SUJITH KURUVILLA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , BALTIMORE 5601 FAVEN BOULEVARD · MD LOCH 21239

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 0 2005

REGORY

32. Registrar's Signature

			1 - For State Registrar	State of Ma			t of Health ar	nd Mental Hy	/giene 2005	28229
*5	Physici	an	Decedent's Name (First, Middle, La	110-	711	0		2. Date of D Month	eath Day Year	3. Time of Death  10:00 A M
	/Medic	al .	4a. Facility Name (If not institution, giv	e street and number)	BLAIR		Town, or Location of	AVG UST Death	4c. County of Dea	
				RIS		1411-4	Tows			
1 2	Funeral Director		5. Social Security Number 247.70.1054  Usual Residence of Decedent	ex 7. Age	(In yrs. last birth	Months	1 Year If Under 24 Days Hours	Min. 8. Date of Bi	ay 936 Sout	nthplace (State or Foreign ountry)  H CAROLNA
	ryland	_	10a. State 10b. County		10c. City, Town					10d. Inside City Limits
	the Ma	ecto	10e. Street and Number		BA	TIMOK 10f. Zip			10g. Citizen of What C	1 TYes 2 No
	th with 23a or	al Dir	1700 N. GAY	St. Apr	# 111	101. 2.10	2/2/8		V.S.	
980	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Heatth and Mental trygiene. ortent: If Item 27 is marked other then "natural; or Iteme 23a or 28a-f show injury or other traumatic event. The Medical Expiration must be notified at injury or other traumatic event.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:		13. Was Deced If Yes, spec	ify Cuban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - Am Black, Wh Specify: B	
2-0	72 ho natur	eted	15. Decedent's En (Specify only highest gra	ducation de completed)	16a. [	Decedent's Usua Give kind of wor	l Occupation k done during most o e retired)	of working	16b. Kind of Busines	s/Industry
21215-0036	d within giene. er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	DA	I CARE	700	_	CHILD	CARE
	i be filed ntal Hygi ed other event. I	Be	17. Father's Name (First, Middle, Last	DAUS			18. Mother	S Name (First, Middle  OARRIE	e, Maiden Sumame)	
Maryland	should and Me s mark umatic	T <sub>0</sub>	NATHANIEL 19a. Informant's Name/Relationship (	Type, Print)	19b. I	Mailing Address	(Street and Number		ber, City or Town, State,	Zip Code)
	t and 2 fealth and 27 I		MIAYANA C. JOHN 20a. Method of Disposition	SON (GRAND L		324 ( Disposition (Name		E AVE.	20c. Location - City o	0 21218
Mor	Pages nent of H ant: If Ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		cemetery,	crematory or of	her nlacel		Α	
Baltimore	permit. Page Department o Importent: If eny injury or once.		21. Signature of Funeral Service Licer	A	1911. 2	22. Name and	Address of Facility	VANGHO	C. GREENE MO 21	FUNGERIC HOM
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do no	t enter the mode	of dying, such as ca		/	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. OVARIAN						Onset and Death
	/Medical Examiner		- 1	Due to (or as a	consequence of	):				
	po tie	Iner	Sequentially list conditions,	Due to for as a	consquence of	):				
۷	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of	):				
8760,		cal		d						
89 xc	death certifica e attending ph d for use as th	//Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy				23d. Date of de	slivery
P.O. Box		by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1□Live birth : 4□Pregnant at 9□ Unknown		3 □Ectopic pre 5 □ Other (spe			Month	Day Year
S, P.	s that t	y Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in t	he underlying ca	ause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ord	w require been sig should b							1 🗆	Yes 2□No 3□P	robably 4X Unknown
Vital Record	The law requires that the ate has been signed by th page 2 should be detache	Completed							opsy prior to death?	utopsy findings available completion of cause of
ital	ian: T	Be C	25. Was case referred to medical examiner?				26. Place o	1 ☐ Yes of Death Check only		s 2□No
of <	Attending Physician: or death. ector: After this certifics by the funeral director.	은	1 ☐ Yes 2 ▼ No 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injury	nt 2 ER/Outp		A Other: 4 Nurs		idence 6 NOther (Spender)	ecify) HOSPICE
ion	ath. r: After	atlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inj	M M	8c. Injury at Work? 1 ∐ Yes 2 ∐ No		now injury occurred	
Division	or Atterde Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ry - At home, farn (Specify)	n, street, factory,	, office	28f. Location City or To	(Street and Number or F own, State)	tural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Co	29a. Certifier 1 Certifying Pt (Check only one)	ysician: To the best on the basis of and manner state	examination and/	death occurred a or investigation,	at the time, date and in my opinion, death	place, and due to the occurred at the time	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner sta	ed.	29c.	License number		29d. Date signed (Mon	th, Day, Year)
)			1				D4372	5	8/26,	105
	5		30. Name and address of person who DR. TARIO MAHMOO				ТТМОЛТ	IIM MIN 914	103	
	Sta				LANEY VA			UM, MD 210	נדע	
	Registr	ar	AUG 3	32. Registra	PARIS 1	C 15 15	- Charles			

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name /First Middle Last **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City wn, or Location of Death Examiner If Under 9. Birthplace (State or Foreign last birthday) Number **Funeral** Months Days Hours 20un 1 M 2 K Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or ftems 23a or 28a-f show other traumatic event, tra Madical Examinar must be ricitlised at 1 Nes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 As Specify: Baltimore, Maryland 21215-0036 þ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. சு 27 fs marked other than (0-12) College (1-4or 5+) LINKNOWN Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) 17. Father's Be sak 19b. Mailing Address (Street and Number of Rural Route Number. City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Department of Health a Important: If item 27 for any injury or other tra 20b Place of Di Date 20c. Location - City or Town, State Pages 1 1 Rurial 3 □ Removal from State S ☐ Other (Specify) <sup>¹</sup> 4 □ Donation 21. Signature of Funeral Service Licenses any in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athensclerch Carchio vascular Fnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? 2 No 1 Yes is after deau...
ral Director: After this cerum...
'... hv the funeral director, p? To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: P 1 🗌 Yes 2 **Z**No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 □ No М 1 Tyes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier 1)43721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back River Necle Rd MALMOUD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2005 Carlons. Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28231 For State Registra Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death August 24, 2005 **Physician** 8:15 PM Dwight David Bloom /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 202 Bynum Ridge Road Forest Hill If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2□F Yrs Director 560-86-0080 Kentucky 53 1951 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA 21050 202 Bynum Ridge Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates: Vietnam White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tand 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 Is markad othar than "r Land Elementary/Secondary (0-12) College (1-4or 5+) 12 Management Supervisor U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bloom Vitousek Mahlon Edward Erna (nmn) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Queenston Street, nt of Health at: If item 27 I Monica Goza - Sister
20a. Method of Disposition Springfield, VA 22152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. \* 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. | 8/31/05 Owings Mills, Maryland 21. Signalu e of funeral service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Um 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Year **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Certification: To Be Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 21 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Tyes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Hospital within 24 hours a fillan Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eath (Item 23a) (Type, Print) 30. Name and address of person who completed ause o 32/Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28232 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8-28-2005 **Physician** 9:47 A M Carnes Roland Brooks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health at Glen Burnie Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3-20-1913 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months 12 M 2□ F 92 Director 215-10-6512 Usual Residence of Decedent the Maryland 10d, Inside City Limits 10b. County 10c, City, Town or Location 10a. State 28e-f show treumetic event. If a Madical Examinary ust be notified at 1 □Yes 25TXNo Director Anne Arundel Linthicum 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ō or Items 23e 21090 U.S.A. 304 Homewood Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed withIn 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: If Yes, Give Year or Dates: ò 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complete permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "na any njury or other treumetic event, If a Mustle once. Elementary/Secondary (0-12) College (1-4or 5+) Davidson Moving & Storage Moving & Storage 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Brooks ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 304 Homewood Rd; Linthicum, MD Mrs. Marguerite Brooks / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ 60rial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8-31-2005 Brooklyn Park, MD Cedar Hill Cemetery 21. Signute of Fune II Service Licerses 22. Name and Address of Facility Singleton Funeral Home PA MO136 Second Ave SW; Glen Burnie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ma /Medical Due to (or as a consequence of): Examiner the Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2□ No 2 No 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? • Hospitel or Attending PI 24 hours after death. • Funerel Director: After th 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 □ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifier icai To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D2630 30. Name and address of person who complete dause of death (Item 23a) (Type, Print) HOSPITAL DR, S. KARIPINENI , 325 M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 3 0 2005

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Items 7,8,20c per in 8647 9-13-05 vt

		1 - For Amend Item 1 1			Cer	iriment of I	lealth and Death		iene 20	05	28233
Physi	cian	1. Decedent's Name (First, Middle, Last) Teofilo B. Bormudo:	Juan	Arzate	Nunez			2. Date of Deat Month	Day	Year	3. Time of Death
/Med ∠ Exam	lical	4a. Facility Name (If not institution, give s		nber)		4b. City. Town.	or Location of Dea		25, 200		2:34 P M
Exam	iner	8504 BONNIE DR					STVILLE				ORGES CO
Funera Directo		5. Social Security Number 6. Sex XX	M 2□F	7. Age (In yrs. las 36 -30-	st birthday) Yrs.	If Under 1 Year Months Days			968 1975	Coun	lace (State or Foreign try) EXICO
and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
Maryl	ţ	Georgia Gwinnett	;		Lawre	enceville	<u>.</u>				1 ☐ Yes 2XQXNo
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wther than "natural", or Items 23a or 28a-f ehow ent, the Medical Examinating Loutilled at	Funeral Director	10e. Street and Number 3405 Sweet Water Ro	ad 51	_4		10f. Zip Code	3004		0g. Citizen of V	What Coun	,
r death	ner	11. Marital Status	2. Was Dece	dent Ever in U.S.	. 13. V	Vas Decedent of I	Hispanic Origin? ( Jan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - Americ	
ours afte	1 by Fu	1 Never Married XX Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Giv Year or Da	<b>2√</b> 2√No e		X Yes 2□ No					spanic
115-( in 72 h	Completed by	15. Decedent's Educ (Specify only highest grade	completed)		(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of wi	orking	16b. Kind of Bu	isiness/Ind	dustry
212 d with giene.	m o	Elementary/Secondary (0-12) unknown	College (1	-4or 5+)		ay 1aboı	-		Constr	uctio	n
Maryland 21215-0036 nd 2 should be filed within 72 hours att lith and Mental Hylgiene. 27 ie markad other than "natural", or traumatic event, the Medical Exercit	To Be (	17. Father's Name (First, Middle, Last) Eleuter Arzate					1	<sub>ame (First, Middle, M</sub> Cacia Nune		е)	
Mary nd 2 shou tith and h 27 is ma		19a. Informant's Name/Relationship (Type Fidelia Arzate	Siste	er			and Number or F	iural Route Number, 1 514 Law			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Exercises meat meat be confilled at		20a. Method of Disposition  1. ☐ Burial 2 ☐ Cremation 3 ☐ A  4 ☐ Donation 5 ☐ Other (Specify)	emoval from	cen	netery, cren	sition (Name of natory or other pla De Tineda	nce)   9/:	Date	oc. Menicho	<b>Sipilo</b> n-Gue	wDeatCoyuca errero, De
Baltir permit. P Departme Importan any injur		21. Signature of Funer Service iconse		1	Bu	Name and Addre	iss-Seitz	Funeral	Home.	Inc.	
		23a. Part1. Emer the disease, or compli- shock, or heart failure. List only on	cations that ca	aused the death.	Do not ente	or the mode of dy	ng, such as cardia	Baltimore	e, Mary	Land	21211 Approximate Interval Between
Physiciai /Medica		Immediate Cause (Final disease or condition resulting in death)		Multiple or as a conseque	o que	uslat a				:	Onset and Death
Examine		Sequentially list conditions, b									
d d ansit	Examiner	il any, leading to intrindiate cause. Enter Underlying Cause (Disease or injury that initiated events	- Due to (	of as a conseque	rice of).						
58760, <cre>cate be executed physicien and the burial-transit</cre>	al Exe	resulting in death) Last	Due to (	or as a conseque	ince of):						3
	edicai										
I Records, P.O. Box 6 The law requires thet the death certific sie hes been signed by the attending rage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live bi	come of pregnance inth 2 Fetal dank at time of dealers	leath 3 🗆	Ectopic pregnanc Other (specify)	у	<del></del>	23d. Dat Mor	e of delive nth	ry Day Year
thet the	by Phy	Part II. Other significant conditions con	tributing to de	eath but not result	ing in the ur	iderlying cause gr	ven in Part I.	23e. Did tob	acco use contr	ibute to th	e cause of death?
cords w requires been sign	ted b							1 □ Ye	s 2 No	3 Proba	abiy 4 □Unknown
Vital Records, sicien: The law requires to certificate hes been signe irector, page 2 should be e	Completed							24a. Was ar autops perform 1 Yes 2	ned?	Vere autor prior to con leath? X Yes	osy findings available inpletion of cause of
Vital F icien: Th certificete ector, pag	Be	25. Was case referred to medical examiner?						eath (Check only one			
of \ Physi r this c	2	1 X Yes 2 □ No H	ospital: 1 □ Ir 28a. Date d		R/Outpatien	3 DUA		Home 5 Reside			SCENE
Vision of Vita Attending Physicien: r death. •ctor: Alter this certific by the funeral director,	ation	1 □Natural 5 □ Pending 2 □ Accident investigation	(Mont)	h, Day Year)	Injury	28c. Inju Wa	rk? Yes 2 No	Subsi	1 54	4	
Division or Attending after death. Director: After	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place buildir	of Injury - At homing, etc. (Specify)		eet, factory, office		28f. Location (Str City or Town	reet and Number, State)	er or Rura	l Route Number,
Division of Vital Reform to the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifying Phys		Backyo		f a Res	me date and also	8504 Beile	ue driv		
To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier  (Check only one)  1 Certifying Physical Examination	ician: 10 the ba and mann	asis of examinatio	on and/or inv	estigation, in my	opinion, death occ	curred at the time, da	use(s) and ma ite and place, a	nner as stand due to	ated. the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	1	0		29c. Licen	se number	29	d. Date signed	(Month, L	Day, Year)
•		> Zabirellar					ME		AUGUST	26, 2	2005
3		30. Name and address of person who co	mpleted cause	e of death (Item 2			STREET,	BALTIMORI	E, MARY	LAND,	21201
Regis	tate	31. Date filed (Month, Day, Year) AUG 3 0 2.0	05 32. P	gistrar's Signatu	re Le A						

State of Maryland / Department of Health and Mental Hygien 9 115

28234 For State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** AUĞÜST 22 BERNICE **BOBER** 2005 8:30 РМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 2827 OUAIL CREEK COURT ELLICOTT CITY HOWARD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. 132-20-0053 79 11/06/1925 N.Y Director Usual Residence of Decedent with the Maryland 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-f ahow traumatic evant. The Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director HOWARD ELLICOTT CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2827 OUAIL CREEK COURT 21042 U.S.A. Pages 1 and 2 should be filed within 72 hours after death 1 nent of Heatlh and Mental Hygiene. int: If itam 27 is marked other than "natural", or Itams 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DENTAL HYGIENIST DENTAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **FELLMAN** NETTIE BUCKNER HERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELLEY GORDON / DAUGHTER 2713 MOORES VALLEY DRIVE - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 20 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 08/26/2005 WOODLAWN, MD BETH TFILOH CONG. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatura Pineral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 a 23a. Part / Enter Ind disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final Privsician disease or condition resulting in death) /Medical Examiner 500 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hespital or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Certification; To Be Completed by 2**X** No 1 ☐ Yes 3 Probably 4 □Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Tyes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the ! 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who comp

State

31. Date filed (Month, Day, Year)

AUG3 0

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2005 For State Registra 1-Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2005 110 411 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dolphin Street 930 If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 1-22-1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1**∑**M 2□ F 220-05-9474 94 Md **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f ahow other traumatic avant, the Modical Examinating ust be notified at Yes 2 No Be Completed by Funeral Director Md N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 501 Dolphin Street 21217 USA or Itams 23a Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hyglene. ant: If item 27 Is marked other than "natural", or Itams 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 245 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Unk Various Jobs Elementary/Secondary (0-12) Laborer Hnk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ollie Curtis Rose Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eliza Mason - Niece P. O. Box 171 Leonardtown, Md 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Important: If its
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8-19-2005 New Cathedral Cem Balto, Md 22. Name and Address of Facility 21, Signature of Funeral Service Licensee March F/H West 4300 Wabash Avenue Balto, Md 21215 29a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death selesoti Immediate Cause (Final ardiovaseugy hero **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** onar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of Examiner the burial-transit be executed Due to (or as a consequence of): Box 68760. Physician/Medlcal The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No 1 ☐ Yes 2 ☐ No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Chack only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dolphin 31. Date filed (Month Pay 32 Registrar's Signature State 0 Registrar

			State of Maryland / Department of Health and M.  1- State of Maryland / Department of Health and M.  Certificate of Death	ental Hyg	iene 2005	28236
	Physici	an		2. Date of Deat Month	h Day Year	3. Time of Death
1	/Medic		Lancard Control of the Control of th	AUG. 21	Day 2005	3;15 P.M.
)	Examin	er	4a. Facility Name (If not institution, give street and number)  FOREST GLEN NURSING HOME  4b. City, Town, or Location of Death SILVER SPRING, I	MD	4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	9 Data of Birth	O Die	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	(Month, Day,	1969 TOWS	ON. MARYLA
	72 hours after death with the Maryland netural', or Items 23e or 28a-f show deat Examiner must be notified at	٦	10a. State   10b. County   10c. City, Town or Location   MD .   PRINCE GEORGE   UPPER MARLBORO			10d. Inside City Limits 1 12 1es 2 □ No
	the M	by Funeral Director	10e. Street and Number 10f. Zip Code	1/	Og. Citizen of What Co	
	with Se or	直	12922 DUNKIRK DRIVE 20772		U.S. OF	
	death ms 2;	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	ncan Indian,
စ္	after or Ite	Ī.	1 ☐ Never Married 2 ☐ Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☐ Wo Specify:	Hican, etc.)	Black, White	
003	ural',	d b	3 Wildowed 4 Divorced Year or Dates:		Specify: BI	
215-0036	"net	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)	ng	16b. Kind of Business/	Industry
212	within iene.	duc	Elementary/Secondary (0-12) College (1-4or 5+) 4 YEARS ATTORNEY		PRIVATE P	RATICE
	fited Hyg other	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name			IMITOD
/lar	could be Menta narkad natic av	To B	ROBERT ELLIOTT CHAMBERS, SR. HOPE AME	BUSH		
Maryland	2 sho and I		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural		•	
	l and lealth im 27 her tr		REGINA CHAMBERS (WIFE) 12922 DUNKIRK DRIVE  20a. Method of Disposition (Name of Disposition (			•
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "netural", or Items 23e or 28e-1 show any injury or other traumatic avent, It e Medical Examiner must be notified at any injury or other traumatic avent, It e Medical Examiner must be notified at ance.		1 Burial 2 Decremation 3 Removal from State NETRO", CREMATOR 8 / 24 / 05 4 Donation 5 Other (Specify)			Town, State JE, MARYLAND
Bal	permit Depar Impor any in		21. Signature of Funda Service Licensee  LEWIT Ond Trugres OW WINN FT  4517 PARK HEIGHTS	S AVENU	JE BALTO	215 -6393 .,MD.
			23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			luk.
	Examiner		Due to (or As a consequence of):			LIEDZE
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			70003.
	rcuted nd transit	Examiner	Cause (Disease or injury that initiated events c.			
,092	te be executed ysician and te burial-transil	EX	resulting in death) Last Due to (or as a consequence of):			
<b>—</b>		dical	d			
9 XC	certifi nding use as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	iverv
Box	that the death ned by the atter detached for u	iciar	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death  5 Other (specify)		Month	Day Year
P.O.	t the by the lache	hys	9 Unknown			
	uires tha signed I id be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
ord	w require been si should l	ted	(xacehostany	1 ☐ Ye	s 2 No 3 Pr	obably 4 Unknown
Records,	law I	Completed	Decalitus.	24a. Was ar autopsy	prior to d	topsy findings available completion of cause of
	r: The			perform 1 Tes 2	death? No 1 ☐ Yes	2 🗆 No
of Vital	Physician: r this certifica ral director, p	Be c	25. Was case referred to medical examiner?  1   Yes   255. No   Hospital: 1   Inpatient   2   EP/Outpatient   3   DOA   Other: 4.57 Nursing Home			
of	y Phy or this oral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2		nce 6 Other (Spec w injury occurred	erry)
ion	Attanding death. ctor: Afte y the fun	atlo	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division	r Atta er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	ital or rs aft ral Di					
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a construction of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	ite and place, and due	to the cause(s)
	with To t	Σ	29b. Signature and title of certifier 29c. License number		d. Date signed (Month	
D	17		Kaman K. ( wo. ) 19609		3-23-05	
_	2'		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 DARNE GAITHERS BURG. MD 20878	ESTOW	N ROAL	Suite 202
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 3 0 2005  32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 15 me G847 9-26-05 tras

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 me G847 9-26-05 tras

Registrar

Registrar 28237 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:14 a Trina D. Clark Aug 23, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/A Maryland General Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2√2 F Director 213-90-4106 May 25, 1975 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exerciner must be notified at 1XYes 2 No Maryland N/A Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 637 Smithson Street 21217 U.S.A. or Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Specify δ. Black 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Clark Donna Arnngton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 637 Smithson Street Baltimore, Maryland 21217 Donna Arrington Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/23/05 \* 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service
1300 Eutaw Place, Baltimore, Md. 21217

Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hypertensive cardiovascular disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine death certificate be executed use as the burial-transil that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Jinknown Marked obesity Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 \[ \] No 24a. Was an certificate has 1 X Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 ER/Outpatient 3 DOA 2 1 Inpatient this tuneral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the Certification: 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 51. BALTIMORE, MD 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygien 2005

2	8	2	3	8
-	•	-	_	_

			1 - State Registrar			Ce	rtificate of	Death			Reg. No.	000	
			1. Decedent's Name (First, Midd	le, Last)						2. Date of Dea		Year	3. Time of Death
	Physici /Medic			Ben	jamin P	hilmore	e Cook			Month August	26, 2	2005	12:30 A M
>	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town,	or Location of	of Death		4c. Cc	ounty of Death	
			8820 Briarcro	Et Lane			Laurel				Pr	ince Ge	orge
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr:	s. last birthday	If Under 1 Year			8. Date of Birt	h Yang	9. Birthp	lace (State or Foreign
	Director		228-01-9013	1 🕅 M 2 🗆 F	87	Yrs.	Months Days	Hours	Min.	(Month, Day Aug 15	, rear) 191	8 Vir	ginia
	D		Usual Residence of Decedent										
	how		10a. State 10b. Count	1	10c. 0	City, Town or L	ocation					1	Od. Inside City Limits
	a Ma	to	MD Prine	ce George	La	urel							1 ☐ Yes 2 🖾 No
	or 28	ire	10e. Street and Number		<u> </u>		10f. Zip Code	-			10g. Citizer	n of What Cour	ntry?
	h wil	aiD	8820 Briarcro	ft Lane			20708				U.S.A	. F	
	deal ms	Funeral Director	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Ori	igin? (Spe	cify Yes or No-	- 14.	Race - Americ Black, White,	
စ္	after or Ite	E.	1 ☐ Never Married 2 💢 Ma		2 🗆 No		1 ☐ Yes 2 🖾 No		i, r deito i	noun, otc./	6.		etc.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene dother than "natural", or Items 23a or 28a-f ahow event, the Madical Exertical mail to mailing an	d by	3 ☐ Widowed 4 ☐ Divorce	Year or	Dates: 1944	-46	103 223110	орвену.			34	pecify: Whit	e
5	natu	Completed		nt's Education est grade completed	1)	(Giv	edent's Usual Occu	a durina mos	t of workin	ng	16b. Kind	of Business/In	dustry
21	within ene. than "	npi	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	9d)					
	e filed within al Hygiene. other than ' vent, fire Ma	Cor	5		-	Carpe	enter					ructio	n
밀	be fill	Be	17. Father's Name (First, Middle	, Last)						(First, Middle,	Maiden Su	ımame)	
<u>X</u>	should be nd Mental marked o	ပ္	John Cook							Powell			
Maryland	2 8 8 8	1	19a. Informant's Name/Relation				ing Address (Stree						•
	1 and 2 Health iem 27		Velma M. Cook	/spouse			) Briarcr	oft La					
ore	of Hez of Hez if Item or othe		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Bernoval from		cemetery, cre	osition (Name of ematory or other pla	ace)	Di	ate	20c. Loca	tion - City or To	own, State
E	Pages ment of ant: if it ury or o		`4 □Donation 5 □ Other (			vy Hil	L Cemeter	y I	Aug 3	0, 05	Laure	el, Mar	yland
Baltimore,	permit. Pages Department of I Important: if It any injury or o		21. Signature of Funeral Service	Licensee		Í	22. Name and Addr Donaldson	ess of Facilit	ty cal H	ome. P.	. A .		
<u> </u>	90 E # 9		LAW AL	telle	M00	773 :	313 Talbo	tt Ave	e. La	urel, N	Maryla	and 207	07-4389
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause or	caused the de each line.	ath. Do not er	nter the mode of dy	ing, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Filysician		Immediate Cause (Final disease or condition		/ 1	beal	thear						Onset and D
	/Medical		resulting in death)	Due t	o (or as a conse			000					
В	Examiner		Sequentially list conditions	b									
7	ed sit	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conse	equence of):							
	scute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
Ö,	ie exe	ũ	resulting in death) cast	Due	o (or as a conse	quence of):							
68760,	certificate be executed rding physicien and ise as the burial-transit	edicai		d									
9 x	ing p	/Med	IF FEMALE:	00. 16									
Bo)	ath co		23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of preg birth 2 Pe	tal death 3	□Ectopic pregnanc	Су			230	<ol> <li>Date of delive Month</li> </ol>	Day Year
<u>o</u> .	the a	Physiciar	1 ☐ Yes 2√ No 9 ☐ Unknown	4∐Pre 9☐Unl	gnant at time of mown	death 5	Other (specify)						17.2
<u>o</u> .	es that the death or igned by the atten be detached for u	Phy	Part II. Other significant condit	ione contributing to	doath but not re	culting in the	undorhino aguso o	was in Bast I		23e Did to	phacon use	contribute to th	ne cause of death?
Ś	res ti	by	Cardiony		death out not re	southing in the	underlying cause g	IAGILIII L GITTI	,			No 3 Prob	
Ö	law requires as been sign 2 should be	ted	1 + 50 =										
Records,	e law has b	Completed	Driay hi	DRILL	700		·			24a. Was autop	sy	prior to cor	psy findings available npletion of cause of
	Th ate pag	Con								1 Tes	2 No	death? 1 ☐ Yes	No
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medic examiner?						of Death	(Check only o	пе)		
of	di S	္	1 □ Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	AU DOW					Other (Specify	1)
	ng Ph ifter th ineral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	18.40	e of Injury onth, Day Year)	28b. Time Injury	Wo			8d. Describe h	ow injury o	ccurred	
5	Attending r death. sctor: After by the fune	ati	2 Accident inves	tigation			M 1	]Yes 2□	No				
Division	ter direct	Certificatio		mined 288. Pla	ce of Injury - At Iding, etc. <i>(Spe</i>	home, farm, s cify)	treet, factory, office		2	8f. Location (S City or Tox		lumber or Rura	l Route Number,
	itel c rrs af ral D		1										
	Hosp 4 hou Fune ely fil	edicai	(Check only 2 Medica	ng Physician: To t I Examiner: On the	basis of examin								
	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Med	one)	and ma	inner stated.			ise number				igned (Month,	
	To To	-	29b. Signature and title of certifi	Δ 1/	7111	140	290 (108)	1 2/	1/2	'	<b>1</b>	Igned (Month,	Day, rear)
,	111		, Mulic	NDV	au		راء	1 77	110		Nyqu	151 4	opalas
	151		30. Name and address of person							Ma : 3		1707	•
		2	William A. Wa		-		George S	t. Lau	ireI,	Maryla	and 20	1/0/	
	Sta		31. Date filed (Month, Day, Year		Registrar's Sig		Sand 8						
	Registr	al	AUG 3	0 2005	CHARLES .	A A	pedi						

State of Maryland / Department of Health and Mental Hygiene 200528239 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 23, 4:48 P M Linwood H. Campbell August 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northampton Manor Health Care Frederick If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) June 1, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1X M 2□ F Yrs. 1913 Director New Jersey 041-05-7862 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f shov 7 is markad othar than "naturaf", or Items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Frederick Maryland Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 17 Altmont Ave. 21788 U.S.A. Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "netural", or Items 23.
ury or other traumatic event, it a Medical Eventional must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: 3 X Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) President Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Campbell Lucy Joslin ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Venetian Dr. Lake Hopatong, NJ 07849 David L. Campbell (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ⚠ Other (Specify Entombment permit. Page Department of Important: If any injury or once. 8-29-05 Newton, NJ St. Joseph Cemetery 21. Signa ure o Funeral Service Licensee 22. Name and Address of Facility Smith-McCracken Funeral Home 63 High St., Newton, NJ 07860 Unen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death active Immediate Cause (Final Leave Confestive Physician disease or condition resulting in death) /Medical Examiner Cardio myopatt Sequentially list conditions, 1 my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequency of); Examiner Hospital or Attending Physician: The law requires that the death cartificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ prostate 1 Yes 2 No 3 Probably 4 No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cutenses 24a. Was an has autopsy 2X No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 💢 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 X Natural 2 ☐ Accident 5 Pending after death. death. 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To tha Funaral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Hag Montclaire

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28240 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** DWIGHT CARTER AUG 451 13:45 27 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SINAI HUSPITAL OF BALTIMORE N/A BAZIMURE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/26/1949 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 56 217-52-7297 1**X** M 2□ F Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits iteme 23a or 28e-f show MD BALTIMORE 1 Yes 2 No Director PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 TENTMILL LANE 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Madical Examiner. XXVever Married 2☐ Married 6 land 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 YEARS ADMINISTRATION STATE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IRA CARTER Mental PEARL ROBINSON Baltimore, Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 19a. Informant's Name/Relationship (Type, Print) item 27 19 TENTMILL LN, APT. C, PIKESVILLE, MD JOI M. CARTER DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 8/30/05 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, isease, or complications that caused the deut. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final Onset and Death METASTATIC PRUSTATE Physician or condition ng in death) 2.5 yrs /Medical Due to (or as a consequence of): Examiner DEPSIS 2-di if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Month 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) el or Attending Physics after death.
I Director: After this ce id in by the funeral director Hospital: 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aff To the Funerel DI completely filled in 1(Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and life of certifier 29c. License number RES-000 August, 27,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL MO HIOSPITAL NWANKWO OF 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 200528241 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 12:00p <sup>M</sup> Leon Ρ. 2005 August 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 **3**M 2 ☐ F 216-07-4548 Maryland 90 June29,1915 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show 1 ☐ Yes 2 X No **Funeral Director** MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 526 Cole Lane 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2€ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify:White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Church Hill Dist. Elementary/Secondary (0-12) College (1-4or 5+) Salesman 12th 17. Father's Name (First, Middle, Last) traumatic event, Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Louis Cohen UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Health of Health or other tra Susan Sibiski /daughter 526 Cole Lane Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or oti 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BayviewCrematory 08 31/2005 Baltimore MD 21. Signature OFuneral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave.Baltimore MD 21221 23a. Part 1. Enter the disease, or complications that ceused the death De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only and cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): **Examiner** NEUTRO PENIA 12 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit 24 HOURS SYNDIUME MYELODYSPLATIC Due to (or as a consequence of) 6 MONTHS IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an autopsy perform 1 🗌 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide . 24 hours a TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 2 6 7 Cenie Mayner, 110 D 0662818 8/27/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 KENRIC MAYNOR, MD S. DECKER AVE. BALTIMORE, MO 32. Registrar's Signature AUG 3 0 2005 Registrar

Box 68760.

P.O.

State of Maryland / Department of Health and Mental Hygiene 200528242 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 8: 34 AM 2005 946451 Alberta /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 707 Calvary Road Churchville Harford If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 K) F Yrs. Director Virginia 1927 225-32-0371 March 28, Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 💢 No Director Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 707 Calvary Road 21028 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced White ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Complet (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Post Master 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Caudill Pearl Mae Nichols Martin Cleveland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau once. Mack E. Caudill - Husband 707 Calvary Road, Churchville, Maryland 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Bel Air Mem. Gardens Bel Air, Maryland 8/30/05 21. Signatur of Fineral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nsequence of): Examiner physician and the burial-transit brovalcu Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobação use contribute to the cause of death? Records, þ SI 1 Nes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 ☐ Yes 2 0 No Division of Vital the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ပ 2 No 1 Yes 4 Nursing Home 5 Desidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 045677 AUGUST. 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. JEIRGEAC. PETERS, 17. D. PLUMTREE ND., SUITE 115, BEL ATR, MP 2/10/4 32. Regis rar's Signature State Registrar

# Florence Carrie Conzermen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

1 104	oc Type of Time in Black indelible line. Ensure	All copies Are Legible.	
r	State of Maryland / Department of Health and	Mental Hygiene 005	28243
ite gistrar	Certificate of Death	Reg. No.	LUZ 40
to the bloom of Class Add day.	- t A)	D. Date of Dooth	2 Time -( D 1)

			1 - State Registrar		C	ertificate of	Death	Re	<b>2. 0 0 0 0 0 0 0 0 0 0</b>	20249													
	Physician /Medical Examiner		1. Decedent's Name (First, Middle, Las	,				2. Date of Deat Month	h Day Year	3. Time of Death													
			Florence Carrie Cunzeman					August	24 2005	6:25 A M													
			4a. Facility Name (If not institution, give Calvert Manor Hea		Center	4b. City, Town, o			4c. County of Dea	ith													
	Funeral Director		213 20 3033	ex 7. Age □M 2½7 F	(In yrs. last birthda 94 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 5,	Year) 1911 Mar	thplace (State or Foreign ountry) Yland													
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic evant, I've Medical Exp. in errorest Le netflied at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits													
		Director	Maryland Harford	đ	Bel A					1 ☐ Yes 2X No													
		rai Dir	1305 St. Franci:				21014		0g. Citizen of What C														
9600		d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 28 No If Yes, Give Year or Dates:	ver in U.S.	3. Was Decedent of I If Yes, specify Cub  1 Yes		pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whi	te, etc.													
5-0	72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De	cedent's Usual Occupive kind of work done	pation during most of work	king	16b. Kind of Business	/Industry													
12	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than " any highry or other traumatic evant, ITE Magnee.	mp	Elementary/Secondary (0-12)	College (1-4or 5+	.) 1	eptionist	a)		Dairy														
Maryland 21215-0036		Be	8 17. Father's Name (First, Middle, Last) Jerome (NMN) Chri					ne (First, Middle, M ne (NMN)	Maiden Surname)														
a)		J.	19a. Informant's Name/Relationship (			ailing Address (Street			City or Town, State, MD 2101														
			20a. Method of Disposition 1 □ Burial 2√ Cremation 3 □	Removal from State	20b. Place of Discemetery, of	sposition (Name of crematory or other pla	сө)	Date	20c. Location - City or														
Baltin			* 4 □ Donation 5 □ Other (Specification of Specification of Service Licentation of Service		7	22. Name and Addre	ess of Facility Ineral Hor	me. P.A.	Towson, MD														
	Pnysician /Medical Examiner	Medical Examiner														23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aA	he death. Do not	enter the mode of dyi	ng, such as cardiac	d, Abingo or respiratory arre	don, MD 21	Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):																		
O. Box 6	that the death certifica led by the attending ph detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year													
ds, P.O	ires that the signed by a be detact	by	Part II. Other significant conditions of Huge tension		not resulting in the	e underlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?													
of Vital Records,	Physician: The law requires that the death or this certificate has been signed by the attendral director, page 2 should be detached for us	Completed	110					24a. Was ar autops perform	v prior to	utopsy findings available completion of cause of													
/ita	stan: artifica	Be (	25. Was case referred to medical examiner?					th (Check only one	θ)														
) t	Physis this o	္ရ	1 Yes 2 No	Hospital: 1 Inpatien		tient 3 DOA			ence 6 Other (Spe	ecify)													
Division	anding Physath. br: After thi	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Year) 28b. Time Injur	y Wo	ry at rk?  Yes 2 □No	28d. Describe ho	Describe how injury occurred														
DIVI	tal or Att s after de al Diract ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, factory, office	The state of the s	28f. Location (Sti City or Town	reet and Number or R n, State)	ural Route Number,													
	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	edical (	29a. Certifier (Check only one)  (Check only one)  (Check only one)	ysician: To the best of niner: On the basis of e and manner state	examination and/or	eath occurred at the ti r investigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)													
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. Licens		25	9d. Date signed (Mon	th, Day, Year)													
			people & Stull	lea mi		2000	48050		8/25/05														
	3		30. Name and address of person who Prashant Shwkla, 31. Date filed (Month, Day, Year)  AUG 3 0 2005	completed cause of deam 155. Pa	ath (Item 23a) (Typer St. +	pe, Print) +400 Abe	rdeen v	nD 2100	> (														
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	de																	
	Registi	ar	AUG 3 0 2003	Decellar.	12 July																		

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar 28244 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 23 2005 **Physician** 8:39 P M Joseph William /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 38 Governors Gate Lane Linthicum Heights If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 15 M 2 ☐ F Yrs 78 Director 215-22-5443 5-20-1927 MD Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic avent, the Madical Examinary ust be notified at 1 □Yes 2000No **Funeral Director** MD Linthicum Heights Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filled within 72 hours after death with it. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 21 any injury or other traumatic avent, the Madical Exemple. 21090 38 Governors Gate Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 A Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1945 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bail Bonds Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence Cox Gerardine Marie Pease 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 408 St. Ives Dr., Severna Park, MD 21146 Mr. Donald Cox / nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Nation 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other Specify) New Cathedral Cemetery 8-26-2005 Baltimore, MD 21. Signature of userals spice Licen 22. Name and Address of Facility Singleton Funeral Home P.A. HOIYII 1 Second Ave SW, Glen Burnie, MD 21061 23a. Part. Externed disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Myolardial Infarction /Medical Due to (or as a consequence of): **Examiner** Due to (or as a disequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 🗌 Yes 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 Yes 2 No 2 / Accident 6 □ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a To the Funeral L pellil 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 25th 2005 051811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO iv. Rolling Ba Himm Thomas Chior, 10 d 31. Date filed (Month, Day, Year) 32. Registrar's a gnatur State AUG 3 0 2005

Registrar

State of Maryland / Department of Health and Mental Hygiene 200528245 For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Lorraine Marie Cremen August 27, 2005 12:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore Co. If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) Birthpface (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M XXF Yrs Director 219-32-8657 69 July 15,1936 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examinant must be notified at 1 Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ітете 23а 7016 Dunhill Road 21222 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 □ Never Married 2 K Married 1 ☐ Yes 2 No Specify: Specify: White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Dental Assistant Dentistry and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be ind Mental I John Laszczynski Theresa Buchynski Baltimore, Mary and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mr. James C. Cremen (Husband) 7016 Dunhill Road Dundalk, Maryland 21222 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition P = 9 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. 4 □Donation 5\O\Other (Specify) Entombment Sacred Ht. of Jesus Cem. 8/31/2005 Dundalk, Maryland ture of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pancientic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown ate hes been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 Yes 2 2 No 1 Tes 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certification: To 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 ANatural 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 3-3 bit of confifier 29c. License number 29d. Date signed (Month, Day, Year) 137302 , un 4ugusT 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V6701 N. Charle St. Balto, Md Z120x 6-BMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			1 - State Registrar	e of Maryland	/ Depa	artment of F tificate of I	lealth and <b>i</b> <i>Death</i>		gien <b>e</b> Reg. No.	005	28246
	Physici	an	1. Decedent's Name (First, Middle, Last)				-	2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Jean  4a. Facility Name (If not institution, give street and	A.		Crosby 4b. City. Town, or	r Location of Death	August		005	5:15 P <sup>M</sup>
ı	Examin	er	106 Waldon Road, Apt			Abing				rford	
	Funeral Director		5. Social Security Number 6. Sex 1 → M 2 ★	7. Age (In yrs. las 7 79	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da July 4	th ly, Year) 192	9. Birthp	place (State or Foreign ntry) ISylvania
	ס		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Lo	cation					Od. Inside City Limits
	Maryla -f shor	ţōţ	Maryland Harford		ingtor						1 ☐ Yes 2 🔀 No
	ith the or 28e	Funeral Directo	10e. Street and Number		ing co.	10f. Zip Code			10g. Citizer	of What Cour	ntry?
	eath w	eral	106 Waldon Road, Apt F	Decedent Ever in U.S.	13 \	2100		pacify Vas or No	14	U.S.A	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Itams 23a or 28e-f show sumatic event, the Medical Examiner must be notified at	by Fun	1 Never Married 2 Married 1 1	of Forces?  /es 2 XNo s, Give or Dates:	'	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2🂢 No	Specify:	o Rican, etc.)		Black, White,	etc.
2-0036	72 hou nature	eted	15. Decedent's Education (Specify only highest grade comple	ted)	16a. Deced	lent's Usual Occup	ation during most of wor	kina	16b. Kind	of Business/In	
2121	within ene. than "	Completed		ge (1-4or 5+)		kind of work done of NOT use retired			Engi	naarina	Company
ام 2	e filed al Hygi othar vant,	Be Co	17. Father's Name (First, Middle, Last)		<u> </u>	30140140	18. Mother's Nan	-			Company
aryland	ould b	To	William Rapp				Anna		andt		
Na	is 1 and 2 should of Health and Men itam 27 la marka other traumatic		19a. Informant's Name/Relationship (Type, Print) Raymond A. Crosby Se	on .		g Address (Street laldon Ro					d 21009
ore,	es 1 and of Health fitam 27 r othar tr		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal 1	20b. Pla		sition (Name of natory or other place		Date		ion - City or To	
Itimore,	Pages tment of I tant: If it		☐Donation 5 ☐ Other (Specify)	TOTT State	cwood	Cemetery	8-31-				aryland
Bal	permit. Pages Department of Important: If it any injury or o		21. Si na re ryneral Service Licensee		10	Name and Address	Road To	owson, M	arylaı		ome, Inc. 04
			23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final	hat caused the death. on each line.	Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
ŀ	Physician /Medical	į	disease or condition	e to (or as a conseque	once of):	a					Myes
	Examiner		Sequentially list conditions, if any, leading to immediate Du	<u> </u>	50	Mes					) some
7	ted insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a conseque	nce of):						
60,	icate be executed physician and s the burial-transit			e to (or as a conseque	nce of):			·			
68760,	tificate ig phys	ledical	d								
Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	in the past 12 months?	s, outcome of pregna <i>nd</i> ive birth 2 ☐ Fetal d reg <i>nan</i> t at time of dea	eath 3	Ectopic pregnancy Other (specify)	,		23d	. Date of delive Month	ery Day Year
P.O.	res that the de signed by the a be detached f		9 Unknown	Inknown	ing in the ur	adarhina agusa air	on in Bort I	220 Did to	obacco uso	contribute to th	an equen of doub?
ords,	w requires the been signers should be constant.	ted by	Tak ii. Other significant conditions contributing	ributing to death but not resulting in the underlying cause given in Part I.				120		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown	
Vital Records,	The law rate has be page 2 sh	Completed						24a. Was autor perfo			psy findings available inpletion of cause of
/ital		Be	25. Was case referred to medical examiner?				26. Place of Dea				
ot	9 9 5	To To	27. Manner of Death 28a. I	Date of Injury 2	R/Outpatien 8b. Time of	t 3□ DOA Oth	y at	ome 5 Residence 1			y)
ion	ttanding Phy death. tor: After thi the funeral o	atlor	2 Accident investigation	Month, Day Year)	Injury	Worl	k? Yes 2 □ No		be now injury occurred		
Division of	el or Attanos atter deatl	Certification;	3 Suicide 6 Could not be determined 28e.	Place of Injury - At homoulding, etc. (Specify)	e, farm, str	eet, factory, office 28f. Location City or T			(Street and Number or Rural Route Number, own, State)		
	To the Hospitel or At within 24 hours after of To tha Funaral Dirac completely filled in by	edical (	29a. Certifier (Check only one) 1 Certifying Physicien: T 2 Leaficel Examiner: On t and	o the best of my knowl he basis of examinatio manner stated.	edge, death in and/or inv	occurred at the ting restigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as si	ated. the cause(s)
	To the within 2 To tha complet	Š	29b. Signature and title of certifier			29c. License	e number		29d. Date s	gned (Month,	
•			20. Name and address of parson who some lated	cause of death (Item 5	239) /T	D34	1931		81	29 10	5
	iD		30. Name and address of person who completed 4136 8 East Joe		λ (Type,	Saltin	Morrill,	MDD	212	36	
	Sta Registr			32. Ağıistrar's Signatu	re Y A	marke					

State of Maryland / Department of Health and Mental Hygien200528247 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 6:00 A.M EVA JUNE COCKEY 26, AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE-GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-05-1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days 1 □ M XX F 81 220-14-1974 WEST VIRGINIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Directo BALTIMORE **IDLEWYLDE** 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 OVERBROOK ROAD 21239 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Æ No tf Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: WHITE þ Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **FEDERAL** Elementary/Secondary (0-12) GOVERMENT College (1-4or 5+) **SECRETARY** YEAR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill tment of Health and Mental H tant: if itam 27 is marked ot Be WILBUR D. GRAHAM VIRGINIA 2 ARBOGAST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADAM D. COCKEY, SR. (HUSBAND) 900 OVERBROOK ROAD, BALTIMORE, MARYLAND, 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any njury or once. 08-29-2005 TIMONIUM, MARYLAND DULANEY VALLEY M.G. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. (R.G.RUTH) K. H. Kutts TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Orapharyngen1
Due to (or as a donsequence of): **Physician** disease or condition resulting in death) weeks /Medical Examiner STYDKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificete hes t director, page 2 s performed? 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after of To the Funeral Direct completely filled in by 4 \( \tag{Homicide} Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 25205 19UST 26, 2005 St. Balto and ZIZOX 6701 31. Date filed (Month, Day, Year) 32. Signature State AUG 3 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005

28248	6	28	2	4	8
-------	---	----	---	---	---

			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	.000	402	4 0																		
	<b>.</b>		1. Decedent's Name (First, Middle, Las	st)				2. Date of De	aath Day	Year	3. Time of	Death																		
	Physici /Medic		Paula Ja	ankowski	Davis			August	26,	2005	7:20	p <sup>M</sup>																		
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of De	eath	4c. Cd	ounty of Death																				
			1990 Emory Road				erstown			Carroll																				
i de la	Funeral Director		5. Social Security Number 6. S  214-54-8466  Usual Residence of Decedent	□M 2GF	6 (In yrs. last birthday	Months Days		in. B. Date of Bir (Month, Date of Bir 2001)  Dec. 30	th 19, Year) 194	9. Birthp Coun Mar	lace (State of htry) yland	r Foreign																		
	show		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside Cit	ty Limits																		
	Mary -f sh	tō	MD Carroll		Re	isterstov	חזי				1 🗆 Yes	2X No																		
	r 28a	Director	10e. Street and Number	1		10f. Zip Code	V 11		10g. Citizer	n of What Coun	itry?																			
	h with	a D	1990 Emory Roa	ıd			21136		U	S.A.																				
	ema ema	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	)- 14.	Race - America Black, White, 6																				
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28a-f show he Wedical Examer must be notified at	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ∑N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ♣ No		0.10 7 110411, 010.7			White																			
5-	"natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation .de completed)	(Give	dent's Usual Occup kind of work done	during most of v	vorking	16b. Kind	of Business/Ind	lustry																			
12	withir ene. than	dw	Elementary/Secondary (0-12)	College (1-4or 5-	+) /// ///	DO NOT use retire	,	10	Do1+4	mara Ca		MD																		
d 2	e filed at Hygie other t		17. Father's Name (First, Middle, Last)			CIVII	Enginee	lame (First, Middle,	-	more Co	unty,																			
an	ould be Mental warked o	o Be	Leon	Jankow	ski, Sr			maline	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Watts																				
Maryland	of Heal	2	19a. Informant's Name/Relationship (					Rural Route Numb	er. City or To																					
			Charles R. Davis	Husband				terstown,			,																			
ē,			20a. Method of Disposition		20b. Place of Disp			Date		tion - City or To																				
E			1 ☑ Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify			M. Cemete	· I	31/05	Upper	co, Mar	vland																			
Baltimore,	in jir		21. Signature of Funeral Service Licen	IS99	1/ - 2	2. Name and Addre		1824 Reis																						
Ω	Dep Imp		Stephen	Meles	Asens E	LINE FUNE	ERAL HOM	E Reister	stown	, MD 21	136																			
*	Physician		23a. Part1. Enter the disease, or comp shock, or heert failure. List only	plications that caused one cause on each lin	the death. Do not en	ter the mode of dyin	ng, such as card	iac or respiratory a	rrest,		Approximate Interval Betw																			
			Immediate Cause (Final disease or condition	Metas	tatir P	wcreat	ic Car	ncer		5	Onset and D	Death																		
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):																									
		L	Sequentially list conditions,	b																										
$\sqrt{}$	ed sit	lne	cause. Enter Underlying Cause (Disease or injury	Due to for as a	consequence of																									
٠ •	certificate be executed iding physician and ise as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):																									
68760,	siciar buria			, i																										
687	ificate g phy as the	/Medical		, d																										
Вох											Physician/N										IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	□Ectopic pregnancy □ Other (specify)	у		23d	I. Date of deliver		ear
0	at the de by the a	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	and or dought - St	_ Other (specify) _																								
٥.	= 60	by Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the t	inderlying cause giv	ven in Part I.	23e. Did to	obacco use	contribute to the	e cause of de	ath?																		
Vital Records,	quires in sign							10	Yes 2 🗗	√o 3 ☐ Proba	ably 4 🗆 U	nknown																		
00	taw raquas been 2 shoult	ompleted						24a. Was		4b. Were autop	sy findings a	vailable																		
æ	The transfer at the page of	mo						autop perfo 1 ☐ Yes	rmed?	prior to com death? 1  Yes	npletion of ca	use of																		
ta		Se C	25. Was case referred to medical				26. Place of D	eath (Check only o		10103																				
_ <	dis is	To B	examiner? 1 \( \text{Yes} \) 2 \( \text{Yes} \) No	Hospital: 1 ☐ Inpatier	t 2 ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing	Home 5 Resid	dence 6	Other (Specify	)																			
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	of 28c. Injur Wor		28d. Describe I																						
Si O	tendi laath. tor: A the fu	cati	2 Accident investigation	1			Yes 2 □ No	_																						
Division	al or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	289. Place of injury - At nome, farm, street, factory, office 281. Loc				28f. Location (S City or Tox	ocation (Street and Number or Rural Route Number, City or Town, State)																					
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 D Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of hiner: On the basis of and manner stat	examination and/or in	h occurred at the tire vestigation, in my control	me, date and pla ppinion, death oc	ce, and due to the curred at the time,	cause(s) and date and pla	d manner as sta	ited. the cause(s)																			
	To t To tl	Σ	29b. Signature and title of certifier	0.0 ~		29c. Licens				igned (Month, D																				
)			I Charlin Das	put w >		DI	5546		augu	ut 29,	2005	,																		
-	10		30. Name and address of person who concers Bagett, u	10. 5601 L	och Ravier	Rod.	Beltimo	re, mo:	21239	7																				
	Sta Registr	_	31. Date filed (Month, Day, Year). AUG 3 0 20	32 Registra	's Signature	and I																								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 11 per inf 8847 9-2-05 vt
State of Maryland Department of Health and Mental Hygiene

2005 28249 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 24, 2005 **Physician** MARY 8:44 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3802 Pinewood Avenue Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Min. | Min. | My (6, 1934) 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2厘F 219-28-8420 Usual Residence of Decedent Yrs. WEST VIRGINI A Director 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r then "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at 1 1 195 2 No mo Director TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3802 AUE 21206 USA INEWOOD Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married . 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 5 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT ACCOUNTING 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Heelth and Mental Hy Importent: If Item 27 is marked oth eny linjury or other traumatic event Que. Be SHIPMAN SHIPMAN IENN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3814 AVE. BALTIMORE, MO 21206 PINEWOOD DAUBHTER 20b. Place of Disposition (Name of Date\_ 20a. Method of Disposition 20c. Location - City or Town, State AUGUST cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State EVANS 25, 2005 FOREST HILL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Licens 22. Name and Address of Facility EVANS 8800 HARFORD RO. PARKUILLE, M2 21274 VALLY Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earl line. tmmediate Cause (Final Arteriosclerotic Cardiovascular Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other:  $_{4} \square$  Nursing Home  $_{5} \square$  Residence & Other (Specify) at SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 XYes 2 □ No Certification: To After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours effer death.
To the Funeral Director: A completely filled in by the fu М investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29s Certifier Certifying Physiciam: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 25, 2005 U, no 30. Name and address of person who completed cau of death (Item 23a) (Type, Print) Theodore King, M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 3 0 2005 Bear & Specker

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 1 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** Delano 9:54 PN August Wilbur 26 2000 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A he John Social Security Number top/cine 8. Date of Birth (Month, Day, ) NOV. 24, 7. Age (In rs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min Months Days Hours 1₩ M 2□ F 216-56-9384 53 1951 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other then "natural", or Itams 23a or 286-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Perry Hall Maruland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 21128 4017 Perry Hall Road U.S.A. by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ltar any injury or other traumatic event, the Mulcal Examination. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Bus 12th Grade Service Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilbur R. Delano, Sr. Mary E. Diegelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4017 Perry Hall Rd., Perry Hall, MD 21128 Mrs. Toni Jo Delano (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ·4 □Donation 5 ØOther (Specify) Entombment Gardens of Faith Maus. 8/30/05 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmenery Pnysician embens hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year į in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No the detached 9 Unknown 9 II Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🛣 No 3 🗋 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No 2 X No To the Hospital or Attending Physicien: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after death. Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 26 2008 Aug ust Res- ucc 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe 600 North 21287-7106 Balkmone, MO David Sinect

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28251 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** The1ma Α. Danz 80 28 2005 10:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Village Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2 XF 89 Director 07/22/1916 Maryland 217**-**18-1846 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show other treumatic event, the Medical Examiner must be notified at Director MD Perry Hall 1 ☐ Yes 2√2KNo Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21236 U.S.A. Heathrow Court or Items 23a 8517 E filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I ☐ Yes 2 ☐ No II Yes, Give X 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced "neturel", Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) self employed 9 manicurist Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Catherine Murphy William Hartman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4112 Pine Hill Road; Perry Hall, MD 21236 Joyce A. Smith / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State ō 1 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, inc. 8/30/2005 Catonsville, MD injury 22. Name and Address of Facility The Johnson Funeral Home, P.A. 21. Signature of Funeral Service Licensee any it 8521 Loch Raven Blvd.: Towson, MD 21286 23a. Harri Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause peach line. men Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 1100 3 Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To 4 Lursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. after death investigation 2 Accident the 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie Po 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygier 1 1 5

2	8	2	5	2
4	0	4	J	4

		1- State Registrer Certificate of Death						Re	Reg. No.			
			Decedent's Name (First, Middle, Las.)	t)				2. Date of Deat	h		3. Time of Death	
	Physicia		Eva Orlena D	avis				Aug 25,	2005	Year	4:05 P M	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County	of Death		
1	_xuiiiii	•	Charles County N	ursing and Rehab.	.	LaPlata	а		Char	·les		
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last bit		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 21,	Year)	9. Birthp	place (State or Foreign	
	Director	ector 579 26 0464 TW XX 79 Yrs.						Aug 21,	T926	Wash	nington DC	
	pud M	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	wn or Loc	eation					Od. Inside City Limits	
	eho d el	5	Maryland Charles			ite Plai	ng			'	1 ☐ Yes 2 🛣 No	
	28e-1	Director	10e. Street and Number		*****	10f. Zip Code		1/	0g. Citizen of V	Vhat Cour	atry?	
	with		10474 Telluri	de Place			695		Unite			
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. W	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-			can Indian,	
ശ	or Iter	Fur	1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 ☐ XXo	lf lf	Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)		k, White,		
ё О	ral', c	l by	XXWidowed 4 □ Divorced	If Yes, Give A.A. Year or Dates:	'	☐ Yes 2 XXX	Specify:		Specify	: W	hite	
Maryland 21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest grad		(Give k	ent's Usual Occupation	during most of work	ing	16b. Kind of Bu	siness/In	dustry	
2	vithin ne. hen	шb	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retired	•		U.S. (	10 WOY	nmont	
S	Hygie Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)		Adm	in. Asst	18. Mother's Name	e (First Middle N			Inneric	
ano	d be	) Be	Marshall Jenkin	15				Orlena H		-,		
7	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-1 ehow any injury or other treumatic event. It Madical Examination in collisis at another.	은	19a. Informant's Name/Relationship (7		b. Mailine	a Address (Street	and Number or Run			State, Zic	Code)	
<u>8</u>			Charles G. Davis				Creek Cou					
Baltimore,			20a. Method of Disposition	20b. Place o	of Dispos	sition (Name of	Sept 1,	Date 2	20c. Location -	City or To	own, State	
E	Page nent c nt: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify				Cemetery		Cheltenh	ıam,	Maryland	
aĦ	rmit. partn porte y inju		21. Sanaty e of Funeral Service Licens				ss of FacilitLee		Home,	[nc.	6633 Old	
<u> </u>	89 = 89		racio Hances.	Storling MO1439	) A	lexandri	a Ferry R	d, Clint	on, MD	2073	35	
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	plications that caused the death. Do one cause on each line.	not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	a Lung C	AN	UR				1	Onset and Death	
Е	/Medical Examiner		resulting in death)	Due to (or all ponsequence	of):							
В		<u>_</u>	Sequentially list conditions,	b. Due to (or as a consequence	of).							
7	nsit	nin	if any, leading to immediate cause. Enter Underlying Cause Disease or highly that initiated events									
V	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	resulting in death) Last	Due to (or as a consequence	of):							
68760,	te be ysicia	cai		. d			<u></u>					
	ertification by the as the	Medicai	Terrine .									
ŏ	th cer tendir r use		23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	h 3□	Ectopic pregnancy	,		23d. Dat Mor	e of delive		
O. B	that the death co	Physician/	in the past 12 modths? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 9☐Unknown		Other (specify)			MOI	I	Day Year	
<u>م</u>	d by the	Phy	Part II. Other significant conditions or	ontributing to death but not resulting	in the un	darking cauca an	on in Part I	23e Did tob	acco use contr	ribute to ti	he cause of death?	
ds,	ires tha signed d be det	d by		withouting to dodn't but not rooming	W. W.O GI	adinying daddo giv	on an aren.	1/0/0			pably 4 Dunknown	
Ö	v requir been si should	etec						24a. Was ar	24b V	Nora auta	may findings quailable	
Records,	has ge 2	Completed						autops:	y ned?/	rior to co leath?	psy findings available mpletion of cause of	
Vital		e Co	25. Was case referred to medical				50 Plans of Pass		-	Yes	2 No	
>	yeicien: The la is certificate has director, page 2	0 B	examiner?	Hospital: 1   Inpatient 2   ER/O	utpatient	3 DOA Oth	er: 4 ursing Ho	me 5 Reside		er (Specif	(v)	
of	F = F	n: T	27. Manner of Death	28a. Date of Injury 28b.	Time of Injury	28c. Injun	y at	28d. Describe ho			,,	
Ö	andin ath. pr: Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		mjury		Yes 2 □ No					
Division	r Attenter deat	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (Sti City or Town		er or Rura	al Route Number,	
Ω	urs af			<u> </u>								
	Hosp 24 hou Fune fely fi	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medicel Exemone)	ysician: To the best of my knowledg niner: On the basis of examination ar and manner stated.	ge, death ind/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the ca ed at the time, da	iuse(s) and ma ate and place, a	nner as s and due to	tated. o the cause(s)	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Mec	29b. Signature and the or certifier	and mailler stated.		29c. Licens	e number	29	9d. Date signed	(Month.	Day, Year)	
	⊬ ≯⊢ ŏ		1/ 20 M	M		DUL	1436		8-	-21	-05	
			30. Name and address of person who o	completed cause of death (Item 23a)	) (Type, F	Print)	100		11 1	0		
	10		Ashvin J. Patel	MD 102 Pa	Ull	nellon	Ct. #11	02 Wa	Laport	IM:	D201002	
	Sta		31. Date filed (Month, Day, Year)	32. Figistrar's Signature		he Me				1		
	Registi	ar	AUG 3 0 2	005 Moseu St	G							

.TC 05-05672 Davis, James

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

s, James		For State Registrar	State	of Maryla	and / Dep <i>Ce</i>	artment <i>rtificate</i>	of Healtl of Dea	h and M <i>th</i>	ental Hyg	ien <b>2</b> 0	05	28253
		1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
Physici /Medio		James Davis							August	-	2005	09:08 A <sup>M</sup>
Examir		4a. Facility Name (If not institution,	give street and	number)		4b. City, To	own, or Locati	on of Death		4c. Count	y of Death	
		2214 Baker Stre	et				timore					
Funeral		5. Social Security Number unk	5. Sex 1 ☑ M 2 ☐ F		rs. last birthday	If Under 1 Months	Year If Uni Days Hou	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign
Director		II - S - id ( D d - id	X	69	Yrs.				Sept 9,	1935	Geor	gia
and *		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or L	ocation					1	Od. Inside City Limits
the Marylar 28a-f show notified at	ō	MD			В	altimo	re					1 ☐ Yes 2 ☐ No
the 128s	Director	10e. Street and Number				10f. Zip C			1	0g. Citizen of	What Cour	ntry?
23a or		2214 Baker Stre	et				212	1 7			USA	
72 hours after death with the Maryland Insture!, or Items 23e or 28e-f show dical Examiner must be notified at	Funerai	11. Marital Status	12. Was De	ecedent Ever in	U.S. 13.	Was Decede			ecify Yes or No- Rican, etc.)		ce - Americ	
after or Ite		1 XNever Married 2 Marrie	d 1 ☐ Ye	Forces? s 2 XNo					Hican, etc.)		ack, White,	
rel',	db	3 Widowed 4 Divorced	If Yes, Year o	Dates:		1 ☐ Yes 2	X 140 3,080			Spec	<sup>′у.</sup> b1	.ack
*naturel', or	Completed	15. Decedent' (Specify only highest		d)	(Give	dent's Usual kind of work	done during r	nost of worki	unk unk	16b. Kind of I	Business/In	dustry unk
be filed within tal Hygiene. Industrial Hygiene. Industrial Here Industrial He	ш	Elementary/Secondary (0-12)		(1-4or 5+)	IITO.	DO NOT use	retirea)					
tygie ther t		unk 17. Father's Name <i>(First, Middle, L</i>	unk				ınk 18. M	other's Name	(First, Middle,	Maiden Suma	me)	1-
ntal hed od od od od o	Be	Tr. Father o Harris (Fried, Friede), 2	2017			·	IIIK IIIK	omor o marrie	(1 11 01, 1111 01:0)	raidoir Gairra		unk
should and Men marke	၉	19a. Informant's Name/Relationsh	n (Type Print)		19b Mail	na Address (	Street and Nu	mber or Rura	l Route Number	City or Town	State Zir	Code)
d 2 s th an trau		Barbara Blue/fi			1				timore,		1217	, 0000)
s 1 end 2 should be filed within 72 hours after death with the Maryla Heelth and Mental Hygiene. Item 27 Ie marked other than "nature!", or Iteme 23a or 28s-f ehov other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition	Tenu	208	. Place of Disp	osition (Name	of			20c. Location		own, State
Pages nent of I nnt: If It		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (Sp			cemetery, cre	matory or otn	er piace)					
permit. Pages 1 end 2 should be filed withir Department of Heelth and Mental Hygiene. Important: If Item 27 Ie marked other than eny Injury or other traumatic event, Item Manages.		21. Signature of Funeral Pervice L	icensee	sta <u>te</u> Direct	or S	2. Name and tate Ai	Address of Fa	acility Board	655 W.	Baltin	nore S	Street
40 = 0		23a. Part1. Enter the disease, or o	411	ue	В	altimo:	re, MD	2120	l			Approximate
Physician / Medical Examiner physician up prize	dical Examiner	disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due	to (or as a cons	sequence of):	10V4SLU	04.5	LUSZ				
It the death certific by the attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 ☐Liv	outcome of pre e birth 2   F egnant at time o known	etal death 3	⊒Ectopic preg ⊒ Other (s <i>pec</i>					ate of delive	ery Day Year
w requires that been signed should be dei	by	Part II. Other significant condition	s contributing to	death but not	resulting in the I	inderlying cau	use given in Pa	art I.		bacco use cor es 2 □ No	ntribute to th 3 ☐ Prob	ne cause of death?
The law requate hes been bage 2 should	Completed							<del></del>	24a. Was a autops perform	sy .	prior to co death?	psy findings available mpletion of cause of
tending Physicien: The leath.  tor: After this certificete he the funeral director, page	Bec	25. Was case referred to medical examiner?					26. P	lace of Death	Check only or	1		
hysic his ce I direc	10	1 Yes 2 No	Hospital: 1	☐ Inpatient 2	☐ ER/Outpatie			Nursing Ho	ne 5∏Reside	ence 6 🗖 Ot	her (Specif	y) Scene
ng Pt ter th		27. Manner of Death 1 Natural 5 ☐ Pending		te of Injury onth, Day Year	28b. Time (	of 280	c. Injury at Work?	1	28d. Describe h	w injury occu	rred	
eath. or: A	cati	2 Accident investig	ation			М	1 ☐ Yes 2	2 □ No				
or Att	ertification;	3 Suicide 6 Could n 4 Homicide determin	1ed   288. Pia	ace of Injury - A ilding, etc. (Spe	t home, farm, st ecity)	reet, factory,	office	;	28f. Location (Si City or Town		ber or Rura	al Route Number,
urs a aral C	O	One Conflict	Manual at all and									
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	(Check only 2 Medical E	Physicien: To xaminer: On the and m	the best of my less basis of exam anner stated.	ination and/or in	in occurred at investigation, in	the time, date n my opinion,	and place, a death occurr	and due to the c ed at the time, d	ause(s) and mate and place	nanner as s , and due to	taled. the cause(s)
To the To the Company	Σ	29b. Signature and title of certifier	.,			29c.	License numb	er	2	9d. Date sign	ed (Month,	Day, Year)
		Hamati Divin	rall, ny	<u> </u>		0.	C.M.E.			August	22,	2005
		30. Name and address of person v	mo completed co				, Balt	imore,	Maryla	nd 2120	01	
Sta	ate	31. Date filed (Month, Day, Year)	32		gnature							
Regist	rar	AUG 3 0 200	5	de S.	A CONTRACTOR OF THE PARTY OF TH	3.0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** EMES /Medical 4a. Facility Name (If not institution, give street and number) Gounty of Death 4b Sity, Town, or Location of Death Examiner IMON eg If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F 45 Director 217-66-5822 08-13-1960 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō natural, or Items 23a 717 DRUID PARK LAKE 21217 Funeral DR. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 3 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. not: If Item 27 Is marked other than "natural", or Itel 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: SpecifyBLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ **FLORENCE** ROBERT NOWLIN SIMMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) /HUSBAND 717 DRUID PARK LAKE DR., BALTIMORE, MD FRANK EATON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GARRISON FOREST VET 09/06/05 OWINGS, MILLS, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 23al-Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONTH UMUN disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, the attending physician Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENXL FRILUNE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Immuni deficieng 1 ☐ Yes 2 ☐ No HUMAN of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this luneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospitel or Attending 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) To the Hospitel within 24 hours are To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TBOWACEMMO301 57 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

AUG 3 0 2005

				State of Maryland / Department of Health and N  1 - State Registrar Certificate of Death		gienę	005	28255
		Physici	an	Decedent's Name (First, Middle Last)	2. Date of De Month	ath Day	Year	3. Time of Death 8:30 Am.
		/Medic Examir		4a. Facility Name (If not institution, give street and number) WEDICH 4b. City, Town, or Location of Death		4c. C	2005 ounty of Death	0.30 %
	1	LXAIIIII	iệi	BALTIMORE WASHINGTON CENTER CLEN BURN,			NE A	LWDEL
		Funeral Director		5. Social Security Number 6. Sex 1 Months 2 F 80 Yrs. 6. Sex 1 Months Days Hours Min.	8. Date of Bird (Month, Da 10-08-	y, Year)	9. Birth Cou KY	olace (State or Foreign ntry)
		ъ		Usual Residence of Decedent	10-00-	-1724	KI	
		anylan ahow	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2204No
		the M	Funeral Director	MD Anne Arundel Glen Burnie  10e. Street and Number 10f. Zip Code		10= Cities	( ) A / h - 1 . C	
9		with 3e or	i Dir	812 Glenview Avenue, SW 21061		U.S.	n of What Cou	ntry?
LAN		death ms 2;	Jera	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sc	pecify Yes or No		. Race - Ameri	
1	ထွ	after or ite	Fur	Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Sive  1 Yes, Sive  1 Yes, Sive	Rican, etc.)		Black, White,	etc.
ENGI	215-0036	ural',	d by	3 □ Widowed 4 □ Divorced Year or Dates: 1963		S	рөсіfу: Wh	ite
الم	15	n 72 l "nati	iete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	king	16b. Kind	of Business/In	dustry
	212	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23e or 28e-f ahow aumatic event, the Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Military		U.S	Gove:	rnment
د		be filed ital Hyg od otha evant,	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle,			
F	Maryland		70	James Henry England Tippie I	Beatrice	2		
1	Mar	d 2 shoutd h and Mer 7 la marke traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rul				
7		1 and Health		Mrs. Irene England / Wife 812 Glenview Ave, SW;  20a. Method of Disposition (Name of	Glen Bu		Mary 1:	
NILLI	altimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	3-2005		lyer, V	
>	altir	그 문원들	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sir				
	ä	permii Depar Impor any ir once.		Mark & Vanuer Mo13571 Second Ave S.W.	Glen Bur	nie,	MD 210	
				23a. Part1. Pater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.				Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition				Onset and Death
		/Medical Examiner		Due to (or as a consequence of):	D. 1			
		-	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Disa	ne	_	
		d d ansit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events c				
,	o,	be executed sician and burial-transit		resulting in death) Last  Due to (or as a consequence of):				
	8760,	cate be executed physician and the burial-transit	dical	d				
	9		/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy				
	Вох	atten atten I for u	cian	in the past 12 months?		230	d. Date of delive Month	Day Year
	P.0.	at the de by the a tached f	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				
		es that igned b	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use	contribute to t	ne cause of death?
	of Vital Records,	w require been sig should b		Jemenlin	1,024	es 2□1	No 3 ☐ Prot	ably 4 Unknown
	ec	e law r has be	Completed		24a. Was autop	SV	prior to co	psy findings available mpletion of cause of
	a F	ician: The l certificate ha rector, page			1 ☐ Yes	rmed? 2.☐ No	death? 1 ☐ Yes	2 🗆 No
	Vit	yaician: iis certifica director, l	o Be	25. Was case referred to medical examiner?  1   Yes   2   No   No   1   Impatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Ho			701 10 11	
		g Phy er this eral d	n: To	27. Manner & Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 ☐ Resid			γ)
	ion	Attanding I death. ctor: After y the funer	atio	2 Accident investigation M 1 Yes 2 No				
	Division	l or Attand after death Diractor: ,	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and N vn, State)	Number or Rura	l Route Number,
2		pital or ours afte naral Dir filled in	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place				S 255
9		To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, control of the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the or red at the time, or	date and pl	id manner as s ace, and due to	ated. the cause(s)
		To the Hosp within 24 ho To the Fune completely f	Me	29b. Signature and title of certifier / / / 29c. License number	:	29d. Date s	igned (Month,	Day, Year)
				MD DS047	0	8/8	26/05	^
_		3		30. Name and address of person who completed cause of death (tem 23a) (Type, Print) SRID/TAR-ATIUM SIOG KITTLE Highway Puno	rdeur	MD	2112	2
		Sta Registr		31. Date filed (Month, Day, Year) AUG 3 0 2005				

State of Maryland / Department of Health and Mental Hygiene, 28256 1 - For State Registrer 005 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 松子 200 **Physician** SHRA ENCARNACION VALDA ESCOBBA 1911 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTOGHERY BETHEJEH SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 03 425 1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months 220-13-2174 77 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other then "naturel", or Items 23e or 28a-f shov treumetic event, the Medical Exertative runst be ricitized at 1 ☐ Yes 2 No Director MONTGOMERY NORTH POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14046 GREAT NOTCH TERRACE 20878 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 3.2 should be filed withir h and Mental Hygiene. 7 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 5+ TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VALDA **ESCOBAR** LOUIS SARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14046 GREAT NOTCH TERRACE - NORTH POTOMAC, MD 20878 it of Health CECELIA AVISON / DAUGHTER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. HILLTOP SERVICE CORP. 08/29/2005 TOWSON, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of uneral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACERATION OF LIVER Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ALL Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 **N**0 3 ☐ Probably ◆☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner?
1 A Yes 2 \( \subseteq \text{No} \) Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Middles on bytimbells Midd & Her contr Eltic or Attending Natural 5 Pending investigation N (330 8/24/05 2**X** No 2 Accident OF 15 STERS. Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide HOTE GLENT NOCH TERM, GAITHERSOLE, MI DAUGHTER'S HOME Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifie and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signal and title of certifier 29c. License number AUGUST 18, 2005 015236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 ROCKVILLY DING ROCKUILLE, MO TOSS? CHAC I. MARGOUS, MIN 32. Registar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2005 Registrar

ALDA, SARA

			1 - For State Registrar	State o	f Marylar	nd / Depa <i>Cer</i>	artment of F	lealth and Death	Mental Hy	giene2 (	005	28257
•	Physici /Medic		1. Decedent's Name (First, Middle Robert Charles						2. Date of Dea Month 08	Day 27	2005	3. Time of Death 1:45 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution Gilchrist Cente	n, give street and nu r for Hos	<sup>mber)</sup> pice Ca	re	4b. City, Town, o Towson	r Location of De	ath		ty of Death imore	
	Funeral Director		5 Social Security Number 215-24-4793	6. Sex 1 <sup>4</sup> M 2 ☐ F	7. Age (In yrs. 75	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		v. Year)	9. Birthpla Count Mary 1	
	g ,		Usual Residence of Decedent  10a, State 10b, County		100 0	ity, Town or Lo						
	aryla shov	٦	MD Balti	more		Lethorp					10	d. Inside City Limits  1 Yes 24 No
	Ne M	ecto	10e. Street and Number				1404 71 72 4					
	th with t	al Dir	5528 Selma Ave				10f. Zip Code 21227			U.S.A.	What Count	у?
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Impartment of health and Mental Hygiene. Instrument of health man Mental Hygiene where the marked other than "natural", or terme 23e or 28e-f show eny injury or other traumatic event, the Martical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 3 Marr 3 Widowed 4 Divorced	Armed Fo	2€ No ve	1	Vas Decedent of H i Yes, specify Cuba	lispanic Origin? an, Mexican, Pui Specify:	(Specify Yes or No- erto Rican, etc.)	BI	ace - America ack, White, e ify: Whit	tc
ה ה	72 ho	eted	15. Deceden (Specify only highes			16a. Deced	lent's Usual Occup	ation during most of w	rorkina	16b, Kind of	Business/Inde	ıstry
7	Athin ne.	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	Mecha:	kind of work done OO NOT use retired	1)	9	Autom	obile	
7	iled w Hygier ther ti		8 17. Father's Name (First, Middle,	( act)		меспа.	IIIC	19 Mother's N	ame (First, Middle,			
2	itd be fi lental H ked of ic ever	To Be	Albert Evans	Last)					Scrivnor	Maioeri Surria	ime)	
a Z	shou and M mar umat		19a. Informant's Name/Relations	hip (Type, Print)					Rural Route Numbe		n, State, Zip (	Code)
Ξ.	and 2 salth a n 27 i		Virginia C. Eva	ns/ Wife		5528	Selma Ave	e. Halet	horpe MD	21227		
20	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐Removal from			sition (Name of natory or other place	(e)	Date	20c. Location		
Daillillor	Pag tment tant:		4 □ Donation 5 □ Other (S	pecify)	Me	Park	dge Memoi	cial; 8-3	1-2005	Elkrid		
Da	Depar Depar Impor		21. Signature of Funeçal Service	Licent	reity	Ž I	Name and Addre mbrose Fi 328 Sulph	ss of Facility ineral H iur Spri	iome, Inc. ing Rd. Ai	butus	MD 212	27
			23a. Part T. Enter the disease or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not ente	er the mode of dyin	g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between
2,50	Physician		Immediate Cause (Final disease or condition	a	1-1	29	meeR					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):						
		ē	Sequentially list conditions,	b. Duato	(or as a consex	quenes of):						
	uted d ansit	Examiner	Sequentially list conditions, fam, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b>								
ĵ	en an rial-tr		resulting in death) Last	Due to	(or as a consec	quence of):						
,00,0	ate be hysici he bu	dicai		d								
Š	entifica ling pl e as t	Med	IF FEMALE:					-				
.O. DO.	o the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours elated death.  of the Funeral Director; After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live t	tcome of pregn birth 2 Feta nant at time of d own	al death 3	Ectopic pregnancy Other (specify)			1	ate of delivery	y Day Year
r (Spin	quires tha n signed I uld be det	by	Part II. Other significant condition	ons contributing to d	eath but not res	sulting in the ur	iderlying cause giv	en in Part I.	23e. Did to	-		cause of death?
	ne law require has been si ge 2 should b	Completed							24a. Was autop	sy	. Were autops prior to com- death?	sy findings available pletion of cause of
9	in: Th	မ င်	25. Was case referred to medical					00 Di (D	1 ☐ Yes	2 No		P No
5	ysicia s cert direct	To B	examiner?	Hospital:	Inpatient 2	TER/Outpatien	3 DOA Oth		eath Check only of Home 5 Resid		her (Sneofy)	Housia
5	ig Phy ter thi		27. Manner of Death	28a. Date		28b. Time of	28c. Injun Worl	y at	28d. Describe h			Hospir -
5	endin sath. or: Af he fur	atic	1 Natural 5 Pendin 2 Accident investig	gation	, 24, 704,	,,		Yes 2 □ No				
	i or Att	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined 286, Place	e of Injury - At hing, etc. (Speci	nome, farm, stre ify)	eet, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
	To the Hospitel or Attending Physician: The lawithing 4 bours either death. To the Funeral Director: After this centificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 X Certifyin (Check only one) 2 Medical	g Physician: To the Examiner: On the b	best of my knows so the best of examinations of examinations of examinations of the best o	owledge, death ation and/or inv	occurred at the tin restigation, in my o	ne, date and pla pinion, death oc	ce, and due to the courred at the time, of	cause(s) and m date and place	nan <i>n</i> er as sta , and due to t	ted. he cause(s)
	othe vithin o the	Me	29b. Signature and title of certifie		ilei stateu.		29c. Licens	e number		29d. Date sign	ed (Month, D	ay, Year)
	4		> 91 Anth	my Rr	les.	an	Das	205	/	tugus	727,	2005
0	6		30. Name and address of person  W. A. L. Lay	GBMC	6701	m 23a) (Type, I	arlos S	t. 130	elto md	2120	x	
V 4	Sta Registr	- 4	31. Date filed (Month, Day, Year) AUG 3 0 20	)05 Jan	legistrar's Sign	ature	r					

8/20/03

State of Maryland / Department of Health and Mental Hygien 205 1- State Unpend Item 23a,pt.II,27,28a-f Certificate of Death Registrar 28258 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MAURICE **FAYAT.I** 25, AUG. 2005 10:00A /Medical 4a. Facility Name (If not institution, give street and number)
V.A.HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY 6. Sex 1 M 2 F If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 220-82-8407 42 Yrs Director 10-17-1962 MD Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worke item 27 is marked other then "natural", or items 23a or 28a-f sho other treumatic event, the Medical Examiner must be notified at Director 1X Yes 2 No BALTIMORE TURNER STATION 10e. Street and Number 10g. Citizen of What Country? 115 WALNUT AVENUE 21222 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No IfYes, Give Year or Dates:1981-84 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 end 2 should be filled within 72 hours after c Depertment of Health and Mentai Hygiene. Innportant: if Item 27 ie marked other then "natural, or lien eny injury or other treumatic event, the Medical Exemples ADRE. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TRUCK DRIVER ASSISTANT MOVING COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSCAR LEE FAYALL MARY ALLEN GREEN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY FAYALL/MOTHER 115 WALNUT AVE. BALTIMORE, MARYLAND 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE VET. CEM! 8-30-05 CROWNSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Aspiration Pneumonitis Due To Inhalation of Foreign Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Body into Left Bronchus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit sician and Due to (or as a consequence of) Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Acute and Chronic Alcoholism 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No hes autopsy performed? /s effer deam.
rei Director: After this ceru...
in by the funeral director, pe 1 Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 Inpatient Certification; To 2X ER/Outpatient 3 □ DOA 27. Manner of Death unk 28c. injury at Work? 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural fnjury 5 Pending 1 ☐ Yes 2 No investigation 8-24-2005 2 X Accident Inhalation of Foreign Body 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) V.A. Hospital filled in by 4 - Homicide To the Hospitei within 24 hours el Baltimore, Md 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical noletely one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E AUG. 26,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

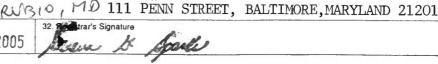
State

Registrar

31. Date filed (Month, Day, Year)

ANA

AUG 3 0 2005



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28259 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Harvey Fritter 1:30 P. M August 28, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Esthers Place Assisted Living Baltimore
If Under 1 Year | If Under 24 Hrs. N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1XIM 2□ F Director 218-12-2436 81 March 10,1924 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10h Count 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2802 Pinewood Ave. 21214 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces?

Day Yes 2 □ No
If Yes, Give Year or Dates: ₩•₩• Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: W.W.II þ White Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7. h and Mental Hygiene. 7 is marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) 80 N/A Maint. Supervisor Filterite 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey Nelson Fritter Icie Virginia Kearns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m eny Injury or other traum once. Robin R. Fritter (Dau hter) 6537 Mt. Vista Road Kingsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. 1, 2005 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Péaceful Adrief Facilities Funeral & Cremation Ctr. P.A. 2325 York Road Timonium, Maryland ter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, healt failure List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition CHRONIC LUNG DISEASE 10 YEARS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No o the Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Box 68760.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAY MD., BALTIMORE VAMO, 10 N. GREENE ST., BALTIMORE 21201

29c. License number

D32186

29d. Date signed (Month, Day, Year)

08-29-2005

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

mad may MD.

32. Registra s Signature 0 2005

State of Maryland / Department of Health and Mental Hygien 2005 28260 State State RegistrAMEND ITEM #2 PER PHY C847 9/02/16/50:216 of Death Reg. No 2. Date of Death 8-28-2005 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** John Marvin Fealy, Sr. August 12:50A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton Prince George's Months Days Hours Min. Sept. 13 1920 9. Birthplace (State or Foreign Country)
PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2/M 2□ F 84 577 - 22 - 9243 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10h County 10a State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exerciner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 12121 Old Colony Drive 20772 permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Alental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other traumatic even. U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2□No 1943− If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: White δ 3 →Widowed 4 □ Divorced Year or Dates: 1946 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Government College (1-4or 5+) Elementary/Secondary (0-12) Supply Officer DOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank I. Fealv Ethel Conley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Fealy, Jr. (Son) 1230 Pine Cone Ct. Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 1, 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify)
21. Signature of Fund 1/15 region Maryland Veterans Cem! Cheltenham. Maryland 2005 22. Name and Address of Facility Lee Funeral Home. Inc. 6633 Old Alexandria Ferry RD Clinton MD 20735 231. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEVERE CORONARY ARTERY DISENSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTINE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ARREST 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No CARDIAC certificate has Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Funaral hours 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 13072 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gurbux Nachnani, MD 8926 Woodyard Rd. #601 Clinton, Md. 20735 31. Date filed (Month, Day, Year) 32. Pojstrar's Signature AUG 3 0 2005 Registrar

PRINCIPAL JULIUS  FREDMANN		For State Registrar	State of Mary	and / Depa	artment of F	lealth and Death		iene 200	5 28261	
UNION MEMORIAL HOSPITAL  South Search Washing   15 Sept		JULIUS		F			Month 8	26 05	6" AMM	
Usual Reservoir of Decicional   100 County   N/A   100 County   100		er	UNION MEMORIAL H	OSPITAL 7. Age (In		If Under 1 Year	BALTIMOR	E 8. Date If Brith	N/A	L.
Content and content of the content	ס		Usual Residence of Decedent	/	9		10013	08/ <del>26/2</del>	<del>:005</del>	HUNGARY  10d. Inside City Limits
Continue of the continue of	th the Marylor 289-f sho	irector				MORE		10	0g. Citizen of What	1 X Yes 2 □ No
Section   Sect		by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1Yes _ 2 M_No If Yes, Give Year or Dates:	16a. Deced	Was Decedent of H f Yes, specify Cuba I Yes 2 X No Hent's Usual Occup kind of work done	Specify: ation during most of wo		14. Race - Ai Black, W Specify:	merican Indian, hite, etc. WHITE
BENDAMN  FRIEDMANN  FR	C 212 filed within Hygiene. other then	0		College (1-4or 5+) 5+						
A Constitution of Control (Specify)   WOODMOR HEBREW   08/26/2005 BALTIMORE, MD   21. Signature   Pineral Service (Levinson & BROS., INC.   8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208   8900 REISTERSTOWN ROAD - PIKESVI	Should be nd Mental marked c	m		pe, Print)						
23. Part. Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Provision Medical Examiner  By Description (Medical Examiner)  By Description (Medical	DEBILITIONS, INIC Department of Health at Department of Health at Important: If Item 271s any injury or other treu once.		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ R 14 □ Donation 5 □ Other (Specify)	lemoval from State	3300 0b. Place of Dispo 105ES MON 100DMOOR	W. STRA sition (Name of TEFI URE HEBREW). Name and Address	THMORE A 08/2 ss of Facility SOL	VENUE-BAL Date 2 6/2005 B LEVINSON	TIMORE, No Pool Location - City  ALTIMORE,  & BROS.,	MD 21215 or Town, State MD , INC.
FFEMALE: 28b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fefal death 4   Pregnant at time of death 5   Other (specify)   23d. Date of delivery Month Day 1   Lives 2   No 3   Probably 4   Month Day 1   Lives 2   No 4   Lives 2   No 5   Lives 2   No 5   Lives 2   No 6   Lives 2	Pnysician /Medical Examiner	aminer	Immediate Øause (Final disease or condition resulting in death)  Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	death. Do not entered assequence of):	er the mode of dyin bral va leart f	such as cardia Suctor Foilure	c or respiratory arre	est,	Approximate Interval Between Onset and Death
25. Was case referred to medical examiner?  1	hat the death certification of by the attending detached for use as	by Physician/Medical	IF FEMALE: 29b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con	3c. If yes, outcome of print   Live birth   2   4   Pregnant at time   9   Unknown	egnancy Fetal death 3 C of death 5 C	Other (specify)			Month acco use contribute	Day Year to the cause of death?
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature anothtitle of certifier  29c. License number  47 243 8946  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Logar Basu, DO  Vinin Memorial Hasp		Completed	(DFD, RTN					24a Was ar	24b. Were	autopsy findings available o completion of cause of
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  8/26/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  8/26/05	inding Physicien ath. After this certifing funeral director.	To B	examiner? 1 Yes 2 No H  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury	28b. Time of	28c. Injun Worl	er: 4 Nursing H y at k?	lome 5 ☐ Reside	nce 6 □Other (Sp	pecify)
John Basu, DO AT 2438946 8/26/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  What Basu, DO Union Memorial Hosp	LIVIS  itel or Atte rs after de el Directo led in by th	Certific	4 Homicide determined	building, etc. (Sp	pecify)			City or Town,	, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lopa Basu, Do Unian Memorial Hosp	To the Hosp within 24 hou To the Funel completely fill	Medical	one)	ner: On the basis of exar	knowledge, death	estigation, in my o	pinion, death occi e number	urred at the time, da	te and place, and d  Od. Date signed (Mo	nth, Day, Year)
State 31. Date filed (Month, Day, Year) 32. egistrar's Signature	101	•	1	isu, DO	Unio	Print) n Mem	ichal i	Hasp		

		T = For State Control State Co		artment of Health and rtificate of Death	Mental Hygier Reg. N	2000 20202
Physici /Medi Examir	cal	Chloe Smith Fox  4a. Facility Name (If not institution, give street and not	mber)	4b. City, Town, or Location of Deat	August 28	Day Year
- Funeral Director		Manor Care Health Service 5. Social Security Number  238-14-8852  6. Sex 1 M 2 XF	7. Age (In yrs. last birthday)	ROSSVIILE If Under 1 Year II Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Baltimore  9. Birthplace (State or Foreign Country)  1915 North Carolina
with the Maryland a or 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore  10e. Street and Number	10c. City, Town or Lo			10d. Inside City Limits 1 □ Yes 2 🛣 No  Citizen of What Country?
5-0036 72 hours after death with the Maryland natural', or Itame 23a or 28a-1 show disal Examitier must be motified at	by Funerai	22 Chandelle Road  11. Marital Status  12. Was Dec Armed F	2 XNo we Dates:	21220  Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	ipecify Yes or No- to Rican, etc.)	S. A.  14. Race - American Indian, Black, White, etc.  Specify: White  Kind of Business/Industry
2127 2127 3d within 1218 within 1118 With	Be Completed	(Specify only highest grade completed,	(Give life.	kind of work done during most of wo DO NOT use retired)  Estate Agent  18. Mother's Nar	Re (First, Middle, Maidd	ealty
Nore, Maryland ges 1 and 2 should be file to 6 Health and Mental Hy to 1 flam 27 is marked oth or other traumatic event	To	Mark Smith  19a. Informant's Name/Relationship (Type, Print)  Robert Fox (Son)  20a. Method of Disposition  1XI Burial 2 □ Cremation 3 □ Removal from	830 N 20b. Place of Dispo	osition (Name of	ural Route Number, City  X. Maryland  Date 20c.	
Baltimore, permit. Pages 1 a Department of Hee Important: If Itam any injury or oths		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  Parallel C Jaffian 3  23a. Part1. Enter the disease, or complications that	McCracker Br	n Cemetery 200 2. Name and Address of Facility ruzdzinski Funera 107 Old Eastern Av	l Home PA venue Esse	rnsville, N.C. 28714 x, Maryland 21221
P (00)  Physician  Indicate the personner of the personne	icai Examiner	shock, or heart lailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.	(or as a consequence of):  (or as a consequence of):  (or as a consequence of):	RATION	e mer	Approximate Interval Between Onset and Death
Hecords, P.O. Box 68/60,  The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit.	Physician/Med	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date ol delivery Month Day Year
COLGS, P. w requires that the been signed by should be detailed.	by	Part II. Other significant conditions contributing to a  Defree  A S + + + + + + + + + + + + + + + + + +	leath but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
	Be Completed	25. Was case referred to medical examiner?		26. Place of De	autopsy performed?  1 Yes 2 15 ath (Check only one)	
on of sing Phys	Certification; To	1 Yes 2 No Hospital: 1 1  27. Manner of Death 1 Natural 5 Pending (Mo) 2 Accident Investigation	Inpatient 2 ER/Outpatier of Injury oth, Day Year)  28b. Time of Injury		dome 5 Residence 28d. Describe how in	
DIVISIC  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide build	e of Injury - At home, farm, sti ling, etc. (Specify) e best of my knowledge, deat	h occurred at the time, date and place	City or Town, Sta	(s) and manner as stated.
To the Ho within 24 t To the Fu completely	Medical	(Check only 2 Medical Examiner: On the I	pasis of examination and/or in iner stated.	29c. License number	urred at the time, date a	nd place, and due to the cause(s)
Sta Regist			se of death (Item 23a) (Type M Renstrar's Signature	Printip BELACE BACT	- more	-28-2005 - MD. 21236

Lowell Gibson 05-05784 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 = For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment o	of Health an of Death	nd Mental I	Hygiene Reg. No		2826
Dhuoi	ian	1. Decedent's Name (First, Middle, Last)		-			2. Date o	Da	y Yea	3. Time of Death
Physic /Med		LOWELL GIBS	SON				Augu		7 200	5 2343
Exam		4a. Facility Name (If not institution, give	street and number)			wn, or Location of C	Death	40	. County of D	eath
1		4128 Townsend Ave				imore	U I	N:		
Funera Director		5. Social Security Number 6. Sep 1 Care 1 Ca		8 Yrs.	If Under 1 Y Months D			Birth Day Year,	966 N	Birthplace (State or Forei
and		10a. State 10b. County	10c. Ci	ity, Town or Lo	cation					10d. Inside City Limi
Marylan f show	Po	MD. N	/ n	RΔT.	rimore	,				1 ☐ Yes 2 ☐ N
178 288	Funeral Director	10e. Street and Number	A		10f. Zip Co			10g. Ci	tizen of What	Country?
3a of	0	4128 TOWSEND AV	ZIPATETP		2122					
death	Jer		12. Was Decedent Ever in L	J.S. 13.	2122 Was Decedent	of Hispanic Origin	? (Specify Yes o	No-		mencañ Indian,
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Itam 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic avent, it a Mudical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates:	İ	if Yes, specify 1 □ Yes <b>火</b> □	Cuban, Mexican, F No Specify:	ruerto Hican, etc.	)	Black, W BI Specify:	hite, etc. ACK
72 ho	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual O	ccupation	f working	16b. K	(ind of Busine	ss/Industry
thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use r	lone during most of etired)	i working			
filed withi Hygiene. other than	ПO	12TH	N/A	NURS	SES AI	D		HOS	PITAL	I
al Hygid I other vant, I	Be (	17. Father's Name (First, Middle, Last)	,			18. Mother's	Name (First, Mic	ddle, Maider	Sumame)	
should be nd Mental marked o	To	WILLIE McLAUGHI	N			JOHN	NIE M.	BECK	HTIW	
2 sho and i is ma		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Si	treet and Number o	or Rural Route No	ımber, City	or Town, State	e, Zip Code)
of Health of Health if item 27 is		JOHNNIE McLAUGE  20a. Method of Disposition  1 Burial 2 Cremation 3 DR		Place of Dispo cemetery, crer	28 TOW sition (Name of matory or other	SEND AV	ENUE B	ALTIM 20c. L	ORE ocation - City	MARYLAND or Town, State
Pages ment of ant: if it	Ш	4 □ Donation 5 □ Other (Specify)		TRO CF	REMATO	RY 8/30	/05	CAT	ONSVI	LLE, MARYL
permit. Pages Department of Important: if it any injury or once.		21. Signature of Funeral Service Lines	WIST GW	VNN T	FWTC	ddress of Facility T.GWYNN	FUNER	\ T   II (	мт 21	215-6393
		23a. Part I. Enter the disease, or composition course (Final	canol and caused the dea	th. Do not en	65nl 7odaBi	ARKsuHEJ	GHT GspiA	<i>K</i> ENUE	BAL	TO Approximate
Physician /Medical Examiner		disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	QALTY quence of):						Onset and Death
ficate be executed physician and s the burial-transit	dical Examiner	causé Enter Undertying Cause (Disease or injury that infliated events resulting in death) Last	Due to (or as a consect	quence of):						
death certifi e attending i d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	aldeath 3 [	Ectopic pregn Other (specif				23d. Date of o Month	delivery Day Year
tuires that n signed t uld be deta	þ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying caus	e given in Part I.		oid tobacco	. /	e to the cause of death?  Probably 4 □Unknow
: The law requires that the cate has been signed by the page 2 should be detache	Completed						— а	Vas an utopsy enformed? es 2 ☐ No	prior t	autopsy findings availab to completion of cause of ? es 2 No
Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			1 -	Death (Check or	nly one)		
Phys this al dir	5	X 195 2□ 140	1 inpatient 2				ng Home 5 ☐ F			pecify) Scene
	lo o	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		ibe how inju	ry occurred	
Atten r deat actor: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place ol Injury - At h building, etc. (Speci	nome, farm, str	M eet, lactory, of	1 ☐ Yes 2 ☐ No fice	28l. Location	on (Street ar Town, State		Rural Route Number,
To the Hospitel or At within 24 hours after or to the Funeral Directompletely filled in by	Medical Ce	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of my knoner: On the basis of examina	owledge, deatl	n occurred at the vestigation, in	he time, date and p my opinion, death o	place, and due to occurred at the ti	the cause(s	) and manner d place, and d	as stated. lue to the cause(s)
thin the mple	Med	29b. Signature and title of certifier	and manner stated.		200 1	cense number		-704 D-	to signed /44-	onth, Day, Year)
7 3 6		Marine On	e Shile a	W		CME				3, 2005
ý ·		30. Name and addre s of person who co	). KOREL		-	Penn Str	eet Bal	timor	e, Mary	yland 21201
Si Regis	ate	31. Date filed (Month, Day, Year) AUG 3 0 2	32. Registrar's Sign	ature	Source !	,				

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H	leaith and Death		ien <b>2</b> 0 0 5	28264
VIII	Physici		1. Decedent's Name (First, Middle, I	GUNTHEL				2. Date of Death	27, 2005	
	/Medio		4a. Facility Name (If not institution, g	RD. APT A	13		ison		BACTION	TORE
	Funeral Director		213-34-9353	Sex 7. Age (In yrs	s last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n (Month, Day,	Year)	Birthplace (State or Foreign Country)  ARY AND
	death with the Maryland ms 23a or 28a-f show rmust be notified at	tor	Usual Residence of Decedent           10a, State         10b, County           MO         BACT		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 289	Funeral Director	10e. Street and Number	1- 17		10f. Zip Code		10	og. Citizen of What	Country?
	eath w	eral	CENTER KD	. HOT. HS	U.S. 13. V	212 Was Decedent of H		(Specify Yes or No-	14. Race - A	merican Indian,
036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23a or 28a-f show other traumatic event, It a Modical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		f Yes, specify Cuba 1 ☐ Yes 2 ☐ No		(Specify Yes or No- erto Rican, etc.)	Specify: 4	thite, etc.  UHITE
21215-0036	n 72 ho	Completed	15. Decedent's (Specify only highest of	grade completed)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of v	vorking	16b. Kind of Busine	ss/Industry
212	er then	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		UTIVE .	ASSISTA	ANT		STRATIVE
Maryland	ld be filed ental Hygi ked other ic event, I	Be	17. Father's Name (First, Middle, La				1	NDLYN	Maiden Sumame)	s . <i>I</i>
aryl	should and Me a mark umatik	P	19a. Informant's Name/Relationship	(Type, Printing of	19b. Mailir	ng Address (Street		Rural Route Number,		
	l and 2 tealth a im 27 l		DIANE DOKGATI	1 - ATIORNEY	137	5. Hop	PLETON	) 57. 6	ACTIMON	E MD 21201 or lown, State
altimore,	egt = r		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	□Removal from State	cemetery, crer	matory or other place	PAPEC F	29.05		
Saltii	permit. Page Department o Important: If any injury or once.		21. Signature Funeral Service Lic		22	. Name and Addre	ss of Facility	EVANS, F	UNERAL	CHAPEC
<b>B</b>	<u>8</u> 05 # 9		23a. Parl 1. Enter the disease, or of	molications that caused the		300 HAR	FORD I	iac or respiratory arre	SINE MO	81254 Approximate
	Physician		Immediate Cause (Final	implications that caused the and by one cause on each Ir e.	VI	or the mode or dyn	.g, 54611 45 5414	acon roophatory arre		Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a Due to (or as a conse	equence of):					
43		e	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	quence of):					
	cuted nd ransit	Examine	Cause (Disease or injury that initiated events	с.						
8760,	certificate be executed rding physicien and use as the burial-transit	al Ex	resulting in death) Last	Due to (or as a conse	equence of):					
9	tificate ng phys as the	fedical		d						
P.O. Box	death e etter	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 □	Ectopic pregnancy Other (specify)	<i>f</i>		23d. Date of Month	delivery Day Year
	S	by Pt	Part II. Other significant conditions	s contributing to death but not re	sulting in the u	nderlying cause giv	ren in Part f.			to the cause of death?
ord	requir een si nould		<u> </u>					-		Probably 4 Junknown
Vital Records,	has has	Completed						24a. Was autops - autops perforn 1 Yes 2	y prior	autopsy findings available to completion of cause of 1?  'es 2 \sum No
/ital	ilcian: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					Death (Check only on		
o	Phys this rai di	. To	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier		4 🗆 Nursing	Home 5 Reside	nce 6 Other (S	(pecify)
ion	Attending in death.	atlor	1/□Natural 5 □ Pending 2 □ Accident investigat	(Month, Day Year)	fniury		rk? Yes 2□No			
Division	ial or Attendest safter deati	Certification:	3 Suicide 6 Could no 4 Homicide determini	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (St. City or Town		Rural Route Number,
	o the Hospital or At thin 24 hours after do the Funeral Direct impletely filled in by	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my ki kaminer: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	me, date and pla opinion, death or	ace, and due to the ca courred at the time, da	use(s) and manner ate and place, and o	as stated. due to the cause(s)
	To the Within 2 To the complete	Σ	29b. Signature and title of curtifier	11		29c. Licens	se number	710 1	9d. Date signed (Ma	onth, Day, Year)
	, 2		30. Name and address of person wh	no completed cause of death (Ite	em 23a) (Type,	Print)	UCT	110 -	TUGUST	d7, 2005
	1		DR. WEIR 20	no completed cause of death (Itel)  32. Registrar's Sign	ST. 3	RD Floor	N.BI	dg. BA	-TIMORE.	MD 21201
	Sta Regist		31. Date filed (Month, Day, Year)	32. Hegistrar's Sign	nature	A 65	2	-		
DI	IMH 17 Rev 1/2	001	7,00	O U LOUS	HU D	Lynne	4			-

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

GOODHEART

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 28266 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Aug 23, 2005 **Physician** Cordelia Marie 5A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8289 Portsmouth Dr Severn Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2(XF 220-05-4188 85 Yrs. Director 7-10-1920 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
shir if item 27 is marked other then "neturel", or items 23s or 28e-f show and it is the control of the control in a Macifical Examination at the nutilist at ury or other treumstic event, it is Macifical Examinations to the control of the con 1 Yes 2 No Directo Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8289 Portsmouth Dr 21144 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. þ 3 ₩Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Solderer Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Wilcox Stinson Loretta Mary Bloom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Smith / Daughter 8289 Portsmouth Dr., Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Donation 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Importent: If any injury or once. 8-27-05 Glen Haven Cemetery Glen Burnie 21. Signary of Funer Sirve Consequents of Funer Fink Funderszi Frome, P.A. MO1148 426 Crain Hwy, SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician emasstive /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine signed by the attending physician and d be detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ₺ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy performed) 2 No 1 Yes 2 No 1 Tyes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cthen: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I To the Hospitel 1 Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exprimer: An the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of co ed cause of death (Item 23a) (Type, Print) 30. Name and address of SIGNOW CHENT 7575 Q. (TCH18 STEPHAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28267 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2005 **Physician** 28, 10:23 P M Elma Katherine Geary August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner COLOTA

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 14, 1919 Cecil 609 Harrisville Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 X F 85 Yrs. 214-30-4985 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural; or items 23s or 28e-f show amy injury or other traumatic event, the Medical Examinating the rigiliary an once. 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☑ No Director Maryland Cecil Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 Harrisville Road 21917 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specity: White Completed by 3 

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Krebs Albert E. Starr, Ir. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2265 Waterview Dr., Nanticoke, MD Mr. William L. Geary, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 09/01/2005 Baltimore, Maryland Parkwood Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 Jelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Penal Inso Hickney 8 yews disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to or a consequence of): Heart Sequentially list conditions Examiner flany laeding to immedia cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit Diabetes Mellitus I that initiated events resulting in death) Last Due to (of as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown steountlmits Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \( \text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8.29.05 D44373 ess of person who completed cause of death (Item 23a) (Type, Print) Rising Sun, MD 21911 Joseph Weidner, 101 Colonial Way. 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State AUG 3 0 2005 Political Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. Date of Death 1. Decedent's Name (First, Middle, Last) GAINES **Physician** HARLENE /Medical Examiner Funeral 9. Birthplace (State or Foreign Days Months MARYLAND 1□M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town pr Location BALTIMORE 1 Yes 2 No **Funeral Director** MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. AKEWOOD 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Mever Married 2 Married BLACK 1 ☐ Yes 2 M No Specify. Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry HEALTHCARE Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. NURSE AIDE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TURMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BATIMORE, MD 21206
Date 20c. Location - City or Town, State Health AVE. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Nourial 2 Cremation 3 Removal from State ö N CENETERY 9.1.05 BAUTIMORE, MARYLAND 22. Name and Address of Facility VAUGHN C. GREENE FUNDAR HM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4905 YORK ROAD BAUTMORE, MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physiclan/Medical Examiner OSIS or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Be Completed by funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 2 No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗆 Homicide To the Hospital of within 24 hours a To the Funerel D 102/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

29c. License numbe

NWACHUKWU, MT

State Registrar

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene 2005 28269 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Ginski, Sr. 11:25P M Robert Joseph August 24, 2005 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 2407 West Branch Road Dundalk Baltimore Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**∑**M 2□F Yrs Director 216-50-1046 57 Feb. 7,1948 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23a or 28a-f ehovine Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Dundalk Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2407 West Branch Road 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2√ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Steel Industry 12 Years ilth and Mental Hygie 27 is marked other i r treumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Joseph Ginski Leocadia Rudzis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: if Item 27 Is any Injury or other treu once. Mrs. Anna M. Ginski (Wife) 2407 West Branch Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date MBurial 2 ☐ Cremation 3 ☐ Removal from State ☐Donation 5 ☐ Other (Specify) Stanislaus Cem. 8/29/2005 Baltimore, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician BLADDER 18 MONTHS /Medical Due to (or as a consequence of) Examiner ARDIOM YOPATHY ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine nding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent oregnant for u 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed: 1 ☐ Yes 20 No 1 ☐ Yes No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home Statement 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 1 Yes ⊅No After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No death. investigation 2 ☐ Accident the within 24 hours after deat To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and name stated. (Check only one) ۽ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title. RES-000 AUGUST 25, 2005 person who completed cause of death (Item 23a) (Type, Print) FECHER M.D. 491 NORTH BROWNING BALTIHORE, MARYLAND 21231

AUG 3 0 2005

AUG 3 0 2005 31. Date filed (Month, Day, Year) AUG 3 State Registrar

Baltimore, Maryland 21215-0036

FOREIGN Examples  FOREIGN Exam	3. Time of Dea	<sup>e</sup> 2005	Reg. No.	2. Date of De	Death	rtificate of L	Cei		iddle, Last)	ame (First, Midd	1 State Registrar  1. Decedent's Nam		, 8
Security Number of the Sunt   Sunt	1:35		t Ze	Month		OLDSTEIN	G					an	
219—12—8301   M. 20   Face   Months   M	N/A	9 Birthol	irth	8. Date of Bi	Mare Cl If Under 24 Hrs.	B21+		Beltim 7. Age (In yrs	pital of	i thegy	Sinzi	er	Examin
10. State   10. County   10. County   10. City, Twen or Location   10. State   10. City	MD MD	3	1923	01/29/	Hours Min.	Months Days	Yrs.	F 82					
The property of the property o	d. Inside City Li	10				cation	y, Town or Lo	10c. C					MOI W
Specify   WHIT   Specify   Specify   WHIT   Specify   Specify   WHIT   Specify   Specify   WHIT   Specify   Specify   WHIT   Specify   Specify   Specify   WHIT   Specify   Specify   Specify   WHIT   Specify   Specify   Specify   Specify   WHIT   Specify	1 ☐ Yes 2 【					RE	ALTIMO		TIMORE	BALT	MD	ctor	Ba-f st
The property of the property o	γ?		_				0	ADT #14	ODCE LANG				a or 2
Elementapy Secondary (0-12)    Elementapy Secondary (0-12)   Collage (1-4or 5-1)   PROPRIETOR	tc.	14. Race - America Black, White, e	0- 14	ecify Yes or No Rican, etc.)		Was Decedent of Hi f Yes, specify Cuba	.S. 13. \	Decedent Ever in d Forces? /es 2 12 No s, Give	12. Was Arm Married 1 [	s arried 2 ☐ Ma	11. Marital Status	þ	al', or items 23 reniner must
Elementary/Secondary (0-12)  12	ıstry	Kind of Business/Ind	16b. Kind	ang	uring most of work.	kind of work done a	(Give	ted)			(Spe	eted	natura dical
17. Father's Name (First, Middle, Mailer Sumane)   18. Mother's Name (First, Middle, Mailer Mamber or Rural Route Number, City or Town, State, Zip C		OIL	0									Sompl	등 등 표현
19a Informant's Name/Relationship (Type, Print)   19b Mailing Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Capenda (Type Town, State, Zip Capenda)   19a Informant's Name/Relationship (Type, Print)   19a Information (Type, Print)			e, Maiden S	e (First, Middle					dle, Last)			Be	d oth
NECHELLE ROBINSON/GRANDDAUGHTER  11222 APPALOOSA DRIVE-REISTERSTOWN, MD 2113  20a. Method of Disposition 10 Burial 2   Command of 10 Burial 2   Co			ber. City or	al Route Numb			19b. Mailir	)	ionship (Type, Prir			ြိ	narke marke matic
1													alth an 27 is r treu
21. Signature of Funeral Service Ucensee  22. Name and Address of Facility  800 REISTERSTOWN ROAD - PIKESVILLE, M.  8900 REISTERSTOWN ROAD - PIKESVILLE, M.  Anshot, or heart failure. List only one cause on each limit disease or condition resulting in death)  22a. Parti. Enter the disease, or complications that cause left the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit disease or condition resulting in death)  Sequentially list conditions, flarly, leading to immediate Cause (Pisnas are or condition resulting in death)  Sequentially list conditions, flarly, leading to immediate Cause (Pisnas are or injury) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequen	n, State	ocation - City or Tov	20c. Loca	Date	•)	sition (Name of matory or other place	Place of Dispo cemetery, crer	20b.	on 3 🗆 Remova	Disposition 2	20a. Method of Dis 1 Burial 2		0 == =
232. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit disease or condition resulting in death)  232. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, and in the shock or heart failure. List only one cause on each limit disease or condition resulting in death)  233. Due to (or as a consequence of):  234. Due to (or as a consequence of):  235. Was decedent pregnant and the past 12 months?  236. If yes, outcome of pregnancy and the past 12 months?  237. If yes, outcome of pregnancy and the past 12 months?  238. Due to (or as a consequence of):  239. Was decedent pregnant and the past 12 months?  230. Due to (or as a consequence of):  230. Was decedent pregnant and the past 12 months?  231. Due to (or as a consequence of):  232. If yes, outcome of pregnancy and the past 12 months?  233. Due to (or as a consequence of):  234. Due to (or as a consequence of):  255. Was decedent pregnant and the past 12 months?  256. Place of Death (Check only one)  257. Was case referred to medical examiner?  258. Was case referred to medical examiner?  259. Was case referred to medical examiner?  250. Was case referred to medical examiner?  251. Was case referred to medical examiner?  252. Was case referred to medical examiner?  253. Was case referred to medical examiner?  254. Was an autopsy to the past 12 months?  255. Was case referred to medical examiner?  256. Place of Death (Check only one)  257. Was case referred to medical examiner?  258. December of the past 12 months?  259. District on the past 12 months?  250. District on the past 12 months?  250. District on the past	INC.	& BROS.,	NSON	OL LEVI	s of Facility SC	2. Name and Addres	22	HALL					Depertm Importar any injui
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of):	Approximate Interval Between Onset and Deat		arrest,	or respiratory a	, such as cardiac	er the mode of dying	h. Do not ent	on each line.	e, or complications List only one caus	neart failure. Lis	shock, or he		5
25. Was case referred to medical examiner?  1	- 4×					Source 1	uence of):	e to (or as a conse	b	conditions, o immediate nderlying o or injury ents	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease o that initiated event	Examin	Medical rial-Iransit
Part II. Other significant contributing to dealin but not resulting in the underlying cause given in Part I.    1	y Day Year		23				death 3	ive birth 2 ☐ Fe regnant at time of	1 4	12 months? 2 No	23b. Was deceded in the past 12 1 \sum Yes 2	ysician/Med	attending for use a
24a. Was an autopsy performed?   24b. Were autopsy performed?   24b. Were autopsy performed?   24c. Place of Death (Check only one)   2	cause of death		/		n in Part I.	nderlying cause give	sulting in the u	to death but not re	ditions contributing	nificant condi	Part II. Other sign	þ	sign d be
27. Manner of Death 1 Manual 27. Manual 27. Manual 27. Manual 27. Manual 27. Manual 27. Manual 28a. Date of Injury 28b. Time of Injury 38b. Time o	sy findings avai pletion of cause	prior to com death?	opsy ormed 2 No	auto perf 1 ☐ Yes									age 2
1 Matural   5 Pending investigation   3 Suicide   4 Homicide   4 Homicide   4 Homicide   4 Suicide   4 Homicide   4 Suicide   5 Pending investigation   Matural   1 Pending		6 □Other (Specific			r	ot 3 DOA Othe	ER/Outpatier	1 Dinpatient 2			examiner?	00	s certi
3   Suicide 4   Homicide 4   Homicide 4   Homicide 5   Suicide 6   Could not be determined 5   Suicide 6   Suicide 6   Suicide 6   Suicide 6   Suicide 6   Suicide 6   Suicide 7   Suicide 7   Suicide 8   Suicide 8   Suicide 8   Suicide 9   Suicide					at ?	f 28c. Injury Work	28b. Time of		ilanig	eath 5   Pend	27. Manner of Dea 1 Natural		n. After th funeral
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	Route Number,					eet, factory, office			uid not be termined 28e.	6 ☐ Coul	3 🗌 Suicide	ertifica	fter ir b
cetto	ted. he cause(s)	s) and manner as stand place, and due to	e cause(s) a	and due to the red at the time	e, date and place, pinion, death occurr	h occurred at the tim vestigation, in my op	owledge, death ation and/or in	he basis of examin	ical Examiner: Or	1 Certify	(Check only		24 hours Funeral stely filled
29c. License number 29d. Date signed (Month, Da	ay, Year)	ate signed (Month, D	29d. Date		number	29c. License		That in or stated.		and title of certif		Me	within Fo the comple
2 D63298 Avenut 24	12000	sust 24	Aus	,	3248	D6		DUD	NYW	>7	•		d.
290. Signature and title of certifier  290. Date signed (Month, Da  290. D	1>	<i>y</i>			0.5	3.1	m 23a) (Type,	cause of death (Ite	son who complete	ddress of perso	30. Name and add		1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20051 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 8:00a M **Physician** William John Ganz, Sr. August 24, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1009 Elm Ridge Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 213-09-6924 91 May 5, **Director** Maryland Usual Residence of Decedent 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show amy njury or other traumatic event, it is Medical Examinat must be notified an once. 10b. County 10c. City, Town or Location 10d. Inside City Limits M☐Yes 2☐No Director Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1009 Elmridge Avenue 21229 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ada Gebhardt John C. Ganz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Amelia B. Ganz, Wife 1009 Elm Ridge Avenue, Baltimore, MD 21229 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Crestiawn Memorial -XBurial 2 ☐ Cremation 3 ☐ Removal from State Marriottsville, MD 4 ☐Donation 5 ☐ Other (Specify) 8-30-05 Gardens 21. Signature of Funeral Service Licens 722. Name and Address of Facility Ambrose Funeral Home, Inc. Q 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) andiophyopathy ICHF Physician Y4 Cer /Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner ASCV resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 🔲 Inpatient

**Examiner** requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

with the Maryland

Baltimore, Maryland 21215-0036

the attending physician and hed for use as the burial-transit detached should be certificate has been page 2 or Attending Physician: director, funeral er deat filled in by

2

Certification:

Medical

27. Manner of Death

1 ANatural

2 Accident

3 🗀 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

24 hours after on Funeral Direct To the Hospital o within 24 hours aff To the Funeral Di completely filled in

State Registrar 29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

1000470

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Old court Rol

(Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MALINDW 31. Date filed (Month, Day, Y

28a. Date of Injury (Month, Day Year)

2005 Regis

2 ER/Outpatient 3 DOA

М

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		For State Registrar		State of	Marylan	id / De <sub>l</sub> <i>C</i> e	partment of e <i>rtificate of</i>	Health <i>Deat</i>	and M h	lental Hy	/giene Reg. No.	200	5	28272
Physicia			me <i>(First, Middle, L</i> as lbert Gais							A Month	eath Day		r	3. Time of Death 1: 25 PM
/Medic Examin	Sec.		(If not institution, givens Healtho		er)		4b. City, Town, Baltimon		n of Death	)	4c.	. County of De	ath	
- Funeral - Director		5. Social Security 174–18–1	1495	ex 7. ⊠M 2□F	Age (In yrs. 85	last birthda Yrs.	y) If Under 1 Yea Months Days		ler 24 Hrs. s Min.	8. Date of Bi (Month, D 06-16-	ith ay, Year) -1920	9. E Pe		e (State or Foreign ) ylvania
ryland		Usual Residence	10b. County			ty, Town or	Location						10d	. Inside City Limits
the Ma	Funeral Director	MD 10e. Street and N	Baltimor	'e	Arbu	ıtus	10f. Zip Code				10g. Cit	izen of What	Country	1 ☐ Yes 2 🙀 No
ath with 23a or	rai Di	5539 Gay	yland Rd.				21227				U.S.			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Examinar must be notified at once.		_	rried 2≹ Married 4 □Divorced	12. Was Deced Armed Forc 1 X Yes 2 If Yes, Give Year or Date	as?		3. Was Decedent of If Yes, specify Cu 1 Yes 2X No	ban, Mexi	can, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Al Black, W Specify: W	hite, etc	
Maryland 21215-0036 nd 2 should be filed within 72 hours att file and Marial Hygidian "neturel", or traumatic event, the Madical Exami	Completed by	(Spe Elementary/Sec 12	15. Decedent's Electify only highest graceondary (0-12)	ducation		16a. De	cedent's Usual Occi ve kind of work don . DO NOT use retir	upation e during m ed)	ost of worki	ng	Soc	ind of Busine ial Se inistr	cur	ity
nd 2 be filed tal Hygi d other	Be	17. Father's Name	e (First, Middle, Last,	)						e (First, Middle	e, Maiden			
Iryla should b of Meni marke matic	2	Joseph G	Jaisior Name/Relationship (	Type, Print)		19b. Ma	illing Address (Stree			≥ Walzy		or Town, State	a, Zip Co	ode)
, Ma			Gaisior/	Wife			Gayland	Rd.		-	-			
Baltimore, permit. Pages 1 ar pepartment of Hea mportant: if tiem in nny injury or other ance.			isposition 2		ate _	cemetery, c	position (Name of rematory or other pi	ery	8-29-		Ba1	cation - City		
Balt permit. Depart Import		21. Signature of	Funeral Service Lice	July	200		22. Name and Add Ambrose I 1328 Sulp	uner hur	cility al Hon Spring	ne, Inc	rbut	us MD	2122	27
Physician		23a. Part1. Enter shock, or he Immediate Cause disease or condit		plications that can one cause on eac	Aspire		enter the mode of dy	ying, such					A	pproximate iterval Between inset and Death
/Medical Examiner	ıer	Sequentially list of any, leading to cause. Enter Unicause (Disease	"	b	Aortic	ster	pneumm							
18760, cate be executed physicien and the burial-transit	ai Examiner	Cause (Disease of that initiated ever resulting in death	115	c. Due to (or	as a consec	quence of):	cardiomycy	ally					-	
687 tificate g physi	ledical			d									1	
Records, P.O. Box 6 The law requires that the death certifit the has been signed by the attending to hagge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	12 months? 2 □ No		th 2 □ Feta ntattime of d	al death	3 □Ectopic pregnan 5 □ Other (specify)					23d. Date of Month	delivery Da	ay Year
rds, P quires that n signed t	by		nificant conditions of	contributing to dea	th but not res	sulting in the	underlying cause o	given in Pa	urt I.			_	Probab	cause of death?
	Completed									per	s an opsy formed?	death	autopsy to comp ? 'es 2	y findings available letion of cause of
Centific City City City City City City City City	Be	25. Was case ref		Hospital:		150/0				Check only				
The state of the s	tion: To	1 Yes 2  27. Manner of De  1 Shatural 2 Accident	eath 5 Pending	28a. Date of (Month)		28b. Time Injur	of 28c. In	ury at ork?		me 5 ☐ Res 28d. Describe			респу)	
STE Division To Attending atter death. Director: After	Certification:	3 Suicide 4 Homicide	6 ☐ Could not b	e 28e. Place o	of Injury - At h g, etc. (Speci	ome, farm, fy)	street, factory, offic				(Street ar own, State		Rural F	Route Number,
Hospita 4 hours Funeralled	edical C	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	nysician: To the b miner: On the bas and manne	is of examin	owledge, de ation and/o	eath occurred at the investigation, in my	time, date opinion, o	and place, death occurr	and due to the red at the time	e cause(s e, date and	) and manner d place, and d	as state	ed. ne cause(s)
To the I within 2. To the I complet	Me	<b>▶</b> ₿	nd title of certifier	m gint	)		D	nse numb 5499	er G		Aug	te signed (Mo	onth, Da	
Y			ddress of person who					, M	9 2	1229				
Sta Registi		31. Date filed (Mi	AUG 3 0	2005 32. Re	garar's Sign	ature J.	Sperte							

		For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of Hertificate of L	ealth and N Death	Mental Hyg	ien <b>2</b> 0 0	5 282	73.
Physici /Medic		1. Decedent's Name (First, Middle, La	ast)	Galla	rdo		2. Date of Deat Month	h	3. Time of D	
Examir	er	Johns Hokins M 5. Social Security Number 17 k 6.	yview Medic	al Center (In yrs. last birthday	4b. City, Town, or  Back  If Under 1 Year  Months Days	MOVE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 11,	4c. County of	Birthplace (State or F Country)	Foreign
Director		Usual Residence of Decedent	**	45 Yrs.			Jan II,	1960	Mexi	
Aarylar f show	ō	10a. State 10b. County		10c.City,Town orl Balti					10d. Inside City	
h the h or 28a-	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Country?	unk
ath wit		427 EasternAVenu	12. Was Decedent E		21: Was Decedent of Hi	202	posity Vac or No-	14 Race	American Indian,	
urs after de al', or Itami	by Funeral	11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	Armed Forces?  1  Yes 2  No If Yes, Give A Year or Dates:		If Yes, specify Cubar	n, Mexican, Puert	exican		White, etc. white	
(C. F. I. 2-UU30 filed within 72 hours after death with the Manyland Hygiene. other than "natural", or Itams 23e or 28e-f show ant, the Madical Exertings Trust be inclifted at	Completed	15. Decedent's (Specify only highest g	rade completed)  College (1-4or 5+	(Giv	edent's Usual Occupa e kind of work done d DO NOT use retired,	luring most of wor	<sub>king</sub> unk	16b. Kind of Bus	iness/Industry	unk
Maryland 21215-UUSO to 2 should be filed within 72 hours af th and Mental Hyglene. 27 is marked othar than "natural", or traumatic avent, tre Marical Exer-	Be	unk 17. Father's Name (First, Middle, Las	unk		unk	18. Mother's Nan	ne (First, Middle, I	Maiden Sumame,	)	unk
aryia should and Men s marka umaric	ပ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street a	und Number or Ru	ıral Route Number	, City or Town, S	tate, Zip Code)	
BAITIMOYE, IMARYIANG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avant, the Marical Examinating the Intillised at ance.		Hopkins Bayview  20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spec	☐Removal from State	20b. Place of Disp	Eastern position (Name of ematory or other place				24 city or Town, State	
Datti permit. Departm Importa any inju	l	21. Signature of Coneral Service ic Ronald S	Wade Dr	2 1/0/1/ E	22. Name and Addres tate Anato Baltimore,	omy Boar		Baltimo	re Street	
Physician		23a. Part1. Enter the disease, or of shock, or heart failure. List/oni Immediate Cause (Final disease or condition	y one cause on each line	the death. Do not e	920	_	or respiratory arm	est,	Approximate Interval Betwee Onset and De	en ath
/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a	consequence of):	LIVER		EASE			
18760, cate be executed physician and the burial-transit	I Examiner	i any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):						
<b>68 / 6U,</b> ificate be ex g physician as the burial	edical		d							
death cert death cert e attending	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3	BEctopic pregnancy			23d. Date Mont	of delivery h Day Ye	ar
<b>(</b> ) 8 5 9	d by Ph	Part II. Other significant conditions  Hep do real		_		en in Part I.	23e. Did to	-	oute to the cause of dea B ☐ Probably 4 ☐Un	
Rec e taw has b	Completed	END STAGE	LIVER	DISI	EASE		24a. Was a autops perfor 1  Yes	sy pr med? de	ere autopsy findings avior to completion of causath?	
of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	or	ath (Check only or	-Aller		
ing ing	tlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injun	4 □ Nursing P	dome 5 ☐ Resid	ence 6 Other		
Division of Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not determine	be des Bless of Inju	ry - At home, farm, . (Specify)	street, factory, office		28f. Location (S City or Tow		r or Rural Route Numbe	er,
Divis  To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical C		Physician: To the best of aminer: On the basis of and manner sta	examination and/or						
To the within To the comp	Ň	29b. Signature and title of certifier	Do Completed cause of discount 4940  32. Pegistra  2005		29c. Licens	e number	2	8/10/2	(Month, Day, Year)	
		30. Name and address of person wh	no completed cause of de	eath (Item 23a) (Typ	e, Print)			0/18/20	003	- 27
		ASSINE DA  31. Date filed (Month, Day, Year)	32 Maistre	r's Signature	N AVENUE	= BALT	MORE,	MA	21224	
Si Regis	tate trar	AUG 3 0	2005	EN A. A.						

State of Maryland / Department of Health and Mental Hygiene 2005 28274 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 8:15 PM Ernest D. Hankins, Jr AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number of BAltimore BAIHMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Mc 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 F Ms 214-62-7403 49 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Md N/A Balto or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5509 Winton Avenue 21207 S A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married **Black** 1□ Yes 2☑No Specify: Specify: Completed by 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Antwerpen Autos College (1-4or 5+) N/A Elementary/Secondary (0-12) 12th grade Auto Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 9 of Health and Mental Ernest D. Hankins, Sr Virginia Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandon J. Hankins - Son 323 Holley Manor Road Catonsville, Md 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Pages 1 Depertment of H Important: If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 8-26-2005 | Randallstown, Md 4 □ Donation 5 □ Other (Specify) Signalure of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabsah Avenue Balto, Md 21215 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final 1 mediate Cause (F Isease or condition resulting in death) BRAINSTEM hEMMORHAGE Physician /Medical Due to (or as a consequence of): Examiner AINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, by Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No within 24 hours after death.

To the Funaral Director: After this c
completely filled in by the funeral dire 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 30 1 ☐ Yes 2 ☑ No UNKNOWN 105 UNK 2 Accident Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide JKNOWN 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier Kerroum/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Apende 31. Date filed (Month, Day, Year) 32. degistrar's Signature State "0 2005 Mare a Registrar

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Dav **Physician** HOWES THERMA 25 ANGUIST 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MOSPITAL SAMARITAN TIMORE
If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/31/1916 If Under 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 F Yrs. MARYIAND 218-32-2763 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Modical Examiner must be notified at 1 Tyes 2 TNo Completed by Funeral Director MD PARKVILLE KALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number JS A 9132 21234 HUONDACE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married □Yes 2 <del>□ N</del>6 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CUNER 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be E1SIE 15URNS HERBERT 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) t of Health NEPHEW AVONDACE HARKVILLE, MD 21234 HOWES 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State AUGUST 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: Many injury or once. GARDENS 29.2005 COSEDALE 4 ☐ Donation 5 ☐ Other (Specify) OF FAITH 22. Name and Address of Facility EVANS FUNERAC CHAPEL 21. Signature of Funeral Service Licenses PAnkvillE, mo 21234 8800 HARFORD RD honnel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOUMNING INFANCTION munos **Physician** /Medical Due to (or as a consequence of) Examiner aronny monery 11/11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed romi the burial-transit . Anninioscumone apploussuum DISEASE Due to (or as a consequence of) Box 68760. Physician/Medical IE FEMALE 23c. ff yes, outcome of pregnancy 1□Live birth 2□Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year Dav 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be de Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perfo certificate 1 Yes Division of Vital the Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending death. 1 Tyes 2 □ No investigation Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Direc 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 215135 M6455 25, 2005 STOOL LOUD PONEW SLVD BOTTMUNG, MD 21234 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Λ, SWIT MD PENELUDIE 31. Date filed (Month, Day, Year UG 3 Registrar

			For 1 _ State	State of Maryla	and / Department of Health and  Certificate of Death			28276
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Death	2. Date of Death	No. No.	3. Time of Death
Н	Physici		Jacob	S. L	Lunes	Month	27 2005	12:2000
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dea	th 3	4c. County of Death	12 0- 121
				IVERSIDE		MP	HARFO	
ı	Funeral Director		5. Social Security Number 6. Sex	M 2□F	rs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min		ear) Coun	
			235-30-8383 A			1-0-19	$\alpha(a \cup b \cdot v)$	irgina
	tryland show	_	10a. State 10b. County	10c. (	City, Town or Location		10	od. Inside City Limits 1 ☐ Yes 2 No
	he Ma 28a-f	ecto	MD HARFOR	20	Tel Hir	10-	Citizen of Miles C	
	with t	Ī	10e. Street and Number	No	10f. Zip Code 21015	109	Citizen of What Coun	ury :
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in		Specify Yes or No-	14. Race - America	
36	d within 72 hours after death with the Maryland Jone. r than "natural", or items 23a or 28a-f show the Medical Examiner rush be indiffied at	y Fu	1 ☐ Never Married 2 ☐ Married	Amed Forces? 1 DYes 2 ☐ No If Yes, Give	1 Yes 2 No Specify:	to rican, etc.)	Specify:	erc.
21215-0036	hours tural',	ed by	3 Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	16a. Decedent's Usual Occupation	16	b. Kind of Business/Ind	U. Ye.
715	in 72 in "nat	plet	(Specify only highest grade	Completed) College (1-4or 5+)	(Give kind of work done during most of wo	orking	1	0 1 1:
212	filed within Hygiene. ther than "	Completed	12		Supervisor	1	tircraft	Moduction
nd	ild be filk fental Hy rked oth tic avent	Be	17. Father's Name (First, Middle, Last)	11	18. Mother's Na	me (First, Middle, Ma	iden Sumame)	1_
Maryland	2 ≤ 6	ဥ	William L.  19a. Informant's Name/Relationship (Ty)	HUPES	19b. Mailing Address (Street and Number or F	C C	Dennett	a Code)
Ma	nd 2 sho alth and 27 Is m r traum		David Hupes	W	1712 RUGET DR. P	ol Air I	mr 2106	_
ore,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition  1  Burial 2 Cremation 3 R	4	b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or To	wn, State
Baltimore	Pag nent snt: i		'4 □Donation 5 □Other (Specify)		VANSFUNERAL CHAPEL 8-1	29-05. F	CRESTHIL	LMO
Ball	permit. Pag Department Important: I any injury o		21. Signature/of Funeral Service License	18 / lad . a	ANS FUNERAL CHAPA S-2 22. Name and Address of Facility	LEST HILL	, MA 2105	Ø.
	HE SHE		23a. Part 1. Enter the disease, or comple	cations that caused the de	eath. Do not enter the mode of dying, such as cardia	APCL-BEL ac or respiratory arrest	AIR. ZNEW	Approximate
	Physician		Immediate Cause (Final	e cause on each line.				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons	tatic Cancer nos	ICKETY	Lyng s.	eural mon!
	Examiner	L	Sequentially list conditions,	. Bus to for on a second	,			
_/	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence on):			
,	execu an and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):			
68760,	ficate be executed physician and is the burial-transit	edical		l				
		Med	IF FEMALE:	3c. If yes, outcome of preg	gnanov			
Вох	death certifi e attending id for use as	Physician/M	in the past 12 months?	1 □ Live birth 2 □ Fe 4 □ Pregnant at time o	etal death 3 Ectopic pregnancy		23d. Date of delive Month	ry Day Year
P.O.	that the de ned by the a detached f	hysl	1  Yes 2 No 9 Unknown	9□ Unknown				
	Se Pe	by Р	Part II. Other significant conditions con	tributing to death but not r	resulting in the underlying cause given in Part I.		cco use contribute to th	
ord	w require been si should I	eted				1 Yes	2 No 3 Proba	ably 4 □Unknown
of Vital Records,	The law sate has b	Completed				24a. Was an autopsy performe	prior to con	sy findings available opletion of cause of
tal		e Co	25. Was case referred to medical		26 Place of Dr		No 1 ☐ Yes	22No
I V	ysic is ce direc	To B	examiner?	lospital: 1  Inpatient 2	Othor		se 6 ☐Other (Specify	)
			27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		28d. Describe how	injury occurred	
Division	Attending or death. actor: After by the fune	icatl	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injury - A	M 1 ☐ Yes 2 ☐ No	28f Location (Street	et and Number or Rural	Route Number
Div	after after Dirac	Certification:	4 ☐ Homicide determined	building, etc. (Spe		City or Town,	State)	rioute ivanicor,
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physical Examination	sician: To the best of my l	knowledge, death occurred at the time, date and place	e, and due to the caus	se(s) and manner as sta	ated.
	To the Howithin 24 To the Forcemplete	Medical	one)	and manner stated.				
	To To	-	29b. Signature and title of certifier		29c. License number	29d	. Date signed (Month, L	Jay, Tear)
7	at 1		30. Name and address of person who do	impleted cause of death (	Item 23a) (Type, Print)	A	agust ?	7, 2005
	91,		nanuel M	Lization	Item 23a) (Type, Print) & Law Gnature	Viet /	Aberd	een,
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature & Specific	7 10111	100	
	Registi	ar	ผมนิง เ	LUUJ PAUJEUN	00 00			

State of Maryland / Department of Health and Mental Hygiene 2005 28277 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 10:23 P™ August 26, Jean C. Halford /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Carroll Westminster Nursing & Rehab Center Westminster If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth Jan 29, 1937 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Mary Land 68 213-34-4414 Yrs Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a State 10h. County 23a or 28e-f show ir then "naturel", or items 23a or 28e-f show the Medical Examiner must be multiled at 1 XYes 2 No Maryland Westminster Completed by Funeral Director Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 3972 Littlestown Pike 21158 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telemarketing Sales treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil timent of Health and Mental Hent: If item 27 is marked ott jury or other treumatic ever Lillian C. Foos Frederick J. Cook 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3972 Littlestown Pike Westminster, Maryland 21158 Venus Ries, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State permit. Pages Department of I Importent: If it any injury or o once. Metro Crematory Inc. 08/29/05 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor <sup>22 Name and Address of Facility</sup> Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) us /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No the detached 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 2 ☐ No Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier se of death (Item 23a) (Type, Print) address of person who cou 30. Name a 688 Pode Road 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 Registrar

	ŀ	1 - State Registrar	08/2070801 Certific	ente of	lepkh an Death		gieneZUU5 leg. No.	
Physici	20	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
/Medic		Maegwendolyn L. Harper				August	25, 2005	12:38 AM
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. 0	_	r Location of D	Death	4c. County of Dear	
		Laurel Regional Hospital	food binds down 1 1611	Laur	el If Under 24	Hre o Day 4 Birds		George's
Funeral Director		5. Social Security Number 217-92-8084 6. Sex 1 M 2 M F 7. Age (In yrs. 4	1 Yrs. Mon			Min (Month Day	1,1964 Nor	thplace (State or Foreign buntry) th Carolina
aryland show	_	10a. State 10b. County 10c. Ci	ity, Town or Location		· · · · · · ·	<del></del>		10d. Inside City Limits
8a-f	Directo	Maryland Prince George's	Laurel					
vith th		9200 Mont Pelier Drive	10f	i. Zip Code	0708		10g. Citizen of What Co	ountry?
s 23	erai	11. Marital Status 12. Was Decedent Ever in U	1 S 13 Was D			? (Specify Yes or No-	USA 14. Race - Ame	nican Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other traumatic event, Ite Medical Evaluate mint the colling any injury or other traumatic event.	by Funerai	Armed Forces?    X   Never Married   2   Married   1   Yes   2   Xes   2   X	If Yes,	specify Cuba	Specify:	uerto Rican, etc.)	Black, Whit	
72 ho "netur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's (Give kind o	Usual Occup	ation during most of d)	f working	16b. Kind of Business	Industry
within ane. <b>then</b>	dm	Elementary/Secondary (0-12) College (1-4or 5+)	Never		-		N/A	
Hygie Hygie ther	ပိ	17. Father's Name (First, Middle, Last)	TICVEL	WOL KEE		Name (First, Middle,		
uld be Nental rked o	To Be	Dalles Monroe			E11	en Faison		
should have		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	lress (Street	and Number o	or Rural Route Numbe	r, City or Town, State, 2	Zip Code)
1 and 2 Health am 27 I		Gregory L. Franklin / Caregiver 20a. Method of Disposition 20b.	9200 Mot	nt Pel	ier Dr		, Maryland	
ages nt of H t: If ite		I Bullat 2 Actellation 3 Premoval noils State	Place of Disposition cemetery, crematory		, ,			
artme orteni injury		*4 □ Donation 5 □ Other (Specify) Me  21. Signature of Funeral Service bigensee	tro Crema				Baltimore,	
Depar Impor any ir		Thomas Gregor	299 <sup>t</sup>	mation Frede	Socie	ty Of Mary oad Baltim	land Inc. ore, Maryla	and 21228
785		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.						Approximate Interval Between
Physician		Immediate Cause (Final	ie					Onset and Death
/Medical		disease or condition resulting in death)  a. Due to (or as a consecution)					16	1 <del>0 Days</del>
Examiner		Sequentially list conditions, b				1		
sit s	Examiner	if any, leading to immediate Due to (or as a consect cause. Enter Inderlying Cause (Disease or injury	quence of):		(	MAPROVED BY MEDICA	LEXAMINER	
xecuti and il-tran	хап	that initiated events resulting in death) Last  Due to (or as a consection)	quence of);		MOLTATION	A PROVED BY MILE		
cate be executed physician and the burial-transit	dicai E	<b>L</b> d			CERTIFICATI	1		
		US SCAMUS.						
w requires that the death certif been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant at time of one of the past 12 months? 4 □ Pregnant at time of one of the past 12 months? 9 □ Unknown	al death 3 ☐ Ectop	oic pregnancy r (specify)	,		23d. Date of del Month	ivery Day Year
law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not re-	sulting in the underlyi	ing cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
require een sig		Mental Retardation				1 □ Y	es 2127No 3∏Pr	obably 4 Unknown
e lar has	ompieted	Respiratory Failure				24a. Was a autops perfor	an 24b. Were at prior to death?	topsy findings available completion of cause of
T Tate	O	OF Was seen referred to modified				1 ☐ Yes	2 No 1 ☐ Yes	2 No
Physician: r this certificatal director,	o Be	25. Was case referred to medical examiner?  1 X Yes 25-No.  Hospital: 1 Inpatient 2 C	ER/Outpatient 3	Oth	OF	Death (Check only or	ence 6 □Other (Spe	oiful
ding Physician: h. After this certific funeral director,	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injun		-	ow injury occurred	City)
ath. r: Afte	atio	1 √Natural 5 ☐ Pending (Month, Öay Year) 2 ☐ Accident investigation	Injury M		k? Yes 2 □ No			
ol or Atte after dea I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be determined 28e. Place of Injury - At he building (Special Could not be det	nome, farm, street, fairly)	ctory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ural Route Number,
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ledical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.	owledge, death occur ation and/or investiga	rred at the tin ation, in my o	ne, date and p pinion, death o	place, and due to the coccurred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
To th Withir To th comp	M	29b. Signature and title of certifier		29c. Licens		_	29d. Date signed (Mont	h, Day, Year)
		M + 170		02	4283		August 2	5, 2005
3		30. Name and address of person who completed ause of death (Ite		011201	Mozer-1	and 20707		
	ı t å	M. Yusuf MD 13631 Baltimore  31. Date filed (Month, Day, Year) 32. Registrar's Sign		aurer,	raryla	and 20/0/	Y. (C)	
Sta Registi								
		AUG 3 0 2005 Measure L	& Should	2		7		C=10005
		I will the same of the	ORIGINAL	10				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 28279 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 12, Helen Herbert August 2005 12:45 PM /Medical 4b. City. Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Anne Arundel Genesis Eldercare Severna Park if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🛛 F Director 287-09-0945 88 Sept. 4, 1916 Kentucky Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov th and Mental Hygiene. 7 Is marked other than "naturel", or items 23s or 28e-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Annapolis Maryland Anne Arundel 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "nether any injury or other traumating." 2712 Riva Road 21401 U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 Nidowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Henry Korte Frances Worland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Herbert (Son) 605 S. Carolina Ave., SE Washington, DC 20003 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Cemetery 8-17-05 Clearwater, FL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Global Gulf Breeze Chapel 21. Sign vire of Funeral Service Licensee 7210 Ulmerton Rd., #J, Largo, FL 33771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ALZHEIMER'S DEMENTA Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician and i for use as the burial-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown HYPERTENSION 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ To the Hospital < within 24 hours a' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signaty ethology D3(136 August 12, 2005) HCC, WD, 9005 KILBRIDE RD, BALTIMO LE, WD

State Registrar

DHMH 16 Ray 6/95

		. Decedent's Name (First, Mic	ddle, Last)								Date of Death Month				3. Time of De
ysician Aedical		CAROLINE		НО	VEY						UGUST_	Day 23,	200	'ear )5	8:55
aminer		a. Fecility Name (If not institu	tion, give s	street and nu	mber)		4b. City, To	own, or Loca	ation of Dea	ith		4c. C	ounty of	Death	
<(2)	-	WASHINGTON BA	ALTIM 6. Sex		DICAL (		GLEN If Under 1	BURNI	E Inder 24 Hrs	8 0	Data of Birth		NE A		
eral ctor		505.16.4592	10	M 2□F		91 Yrs.			ours Min	1.	Date of Birth Month, Day, AN 10,	Year) 1914		Coun	lace (State or Fo try) <b>H_DAKOT</b> ,
=	-	Suel Residence of Decedent  Oa. State 10b. Cour			10c. Ci	ity, Town or Lo	cation							10	Od. Inside City L
to to		MD ANNE	ARIIN	DET	AT	NNAPOLI	·c								1 ☐ Yes 2[
Director	1	0e. Street and Number	AKUI	171511		WAL OUT	10f. Zip C	ode			10	g. Citize	g. Citizen of What Country?		
anth rain		22 MARYLAND	AVE				214						USA		
Examiner must be nutified at by Funeral Director		Marital Status     Never Married 2 Nover Married Nover Mar	farried	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or D	<b>X</b> X No		Was Deceder If Yes, specify 1 ☐ Yes	y Cuban, Me	ic Origin? (; exican, Pue ecify:	Specify into Rica	Yes or No- in, etc.)			White,	
		15. Deced	ient's Educ	cation		16a. Dece	dent's Usual	Occupation			1	6b. Kind	of Busi	WHI ness/Ind	
Be Completed	-	(Specify only hig Elementary/Secondary (0-12		College (	1-4or 5+)	life.	kind of work DO NOT use	retired)	most of wo	orking					
ပ္ပ		12		4		HOME	MAKER						HON		
0	1	7. Father's Name (First, Midd THOMAS HALL	lle, Last)								rst, Middle, M E PARK		umame)		
any injury or other traumatic event, that Monee.  To Be Comp		9a. Informant's Name/Relation									ute Number,				Code)
ther	2	Oa. Method of Disposition	THANL	·	20b.	Place of Dispo	sition (Name	of		Date	-				wn, State
y or o		1XXBurial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		emoval from	State	cemetery, crei	natory or oth	er place)	   D 20	200				•	,
in a	1	21. Signature of Funeral Sept		ø //	BEI	REA CEM		Address of	B.29			BERE	A,KI	-	
Sun Sun Sun Sun Sun Sun Sun Sun Sun Sun		Valla	/	111			INK FU				.A. N BURN]	ו קוז	MTD 2	106	ı
iner			_												
e burial-transit	t	Sequentially list conditions, any, leading to immediate augus. Enter underlying Lause (Disease or injury hat initiated events esulting in death) Last			(or as a consec										
edicai	t	any, leading to immediate ause. Enter underlying ause (Disease or injury hat initiated events esulting in death) Last  FFEMALE:  3b. Was decedent pregnant	2	Due to	(or as a consec	quence of):	Detanya praga	nancy				23	d. Date (		,
edicai	t	any, leading to immediate ause. Enter underlying cause (Disease or injury hat initiated events esulting in death) Last	2	Due to  Due to  Due to  Due to	(or as a consection of pregnicith 2 Test	quence of): nancy al death 3	Ectopic preg Other (spec					231	d. Date o		ry Day Year
edicai	t	early, leading to immediate ause. Enter underlying ause. Enter underlying ause. (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  art II. Other significant conductions.		Due to  Due to  Control  Due to  Due to	(or as a consection of pregners) for the come of pregners and at time of cown	quence of): lancy al death 3 [ death 5 [	Other (spec	city)	Part I.				Month	1	Day Year
pe 2 should be detached for use as the bur mpleted by Physician/Medical	t	early, leading to immediate ause. Enter underlying ause. Enter underlying ause. (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  art II. Other significant conductions.	ditions con	Due to  Due to  Control  Due to  Due to	(or as a consection of pregners) for the come of pregners and at time of cown	quence of): lancy al death 3 [ death 5 [	Other (spec	city)	Part I.		1 Tes	acco uses 2 🗆	Month contribution No 3 24b. We price	ute to th	Day Year e cause of death ably 4 2 Unknown one findings available in or cause
or. page 2 should be detached for use as the bur  Completed by Physician/Medical	r P P	any, leading to immediate ause. Enter underlying ause. Enter underlying ause. (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions are in the past 15 No 9 Unknown.	ditions con	Due to  Due to  Control  Due to  Due to	(or as a consection of pregners) for the come of pregners and at time of cown	quence of): lancy al death 3 [ death 5 [	Other (spec	orfy)			1 Tes	acco uses 2 Decided?	Month contribution No 3 24b. We price	ute to th Proba	Day Year e cause of death ably 4 2 Unknown one findings available in or cause
Il director, page 2 should be detached for use as the bur  To Be Completed by Physician/Medical	P 2	FFEMALE:  23b. Was decedent pregnant in the past 12 months?  1	ditions con	Due to  3c. If yes, out 1 Live to 4 Pregr 9 Unknown tributing to do	(or as a consection as a consection of pregning the 2 Februard at time of cown	quence of): lancy al death 3 [ death 5 [	Other (spec	use given in	Place of De	eath (C/	1 Yes  24a. Was an autopsy perform 1 Yes 2	ed?	Month contribution No 3 24b. We price dea	Proba	Day Year e cause of death ably 4 Munkr osy findings ava npletion of cause 2 No
tion: To Be Completed by Physician/Medical	P 2	any, leading to immediate ause. Enter underlying ause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1	ditions con	Due to  3c. If yes, out 1 Live to 4 Pregr 9 Unknown tributing to do	(or as a consection as a consection of pregning the 2 Fetiliant at time of cown	quence of): lancy al death 3 [ death 5 [ sulting in the u	Other (spec	use given in	Place of De	eath (C/	1 Yes  24a. Was an autopsy perform 1 Yes 2	ed?	Month Contribution No 3 24b. We price dea 1	ute to th Proba pre autopor to contaith? Yes (Specify	Day Year e cause of death ably 4 Munkr osy findings ava npletion of cause 2 No
tion: To Be Completed by Physician/Medical	P 2	any, leading to immediate ause. Enter underlying ause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 33b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  art II. Other significant condexaminer? 1   Yes 2   No   7. Manner of Death 1   Rilatural   5   Per   2   Accident   3   Suicide   6   Cou	ditions con	Due to  Due to  Cospital:  28a. Date (Mon)	(or as a consection as a consection of pregning the 2 Februard at time of cown	quence of):  lancy al death 3 [ death 5 [ sulting in the u  ER/Outpatier 28b. Time o Injury	Other (special other special o	26. Other: 4 c. Injury at Work?	Place of De	Home 28d.	1 Yes  24a. Was an autopsy perform 1 Yes  1 Yes  1 Resider  Describe how	ed?  Ance 6 [av injury content and the second secon	Month contribi	ute to th Proba	Day Year e cause of death ably 4 Munkr osy findings ava npletion of cause 2 No
tion: To Be Completed by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   2   Unknown   2   Yes   2   No   3   Unknown   2   Accident   3   Suicide   6   Cou   4   Homicide   2   Homicide   2   Assert   3   Certifier   4   Certifier   4   Certifier   5   Certifier   6   Certifier   7   Certifier	ditions con	Due to    Due to	come of pregninth 2 Fetiant at time of cown eath but not resident 2 for injury th, Day Year)	quence of):  lancy al death 3 [ death 5 [ sulting in the u  LEP/Outpatier 28b. Time of Injury  loome, farm, str	other (special and and and and and and and and and and	26. Other: 4 C. Injury at Work? 1 Yes	Place of De	Home 28d. 28f.	1 Yes  24a. Was an autopsy perform 1 Yes  24c only one 5 Resider  Describe how  Location (Stric City or Town,	ed? No  nce 6 [ v injury c  use(s) and / State)	Month  contribution  24b. Weapring dea 1   Other  Occurred	ute to th Proba ore autoport to con ath? Yes (Specify	Day Year  e cause of deatl ably 4 2 Unkr  osy findings ava npletion of cause 2 No  Route Number,
tion: To Be Completed by Physician/Medical	P 2	any, leading to immediate ause. Enter underlying ause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown art II. Other significant concentration of the past 12 months? 1   Yes 2   No 9   Unknown art II. Other significant concentration of the past 12 months? 1   Yes 2   No   Yes   ical Handing astigation ald not be ermined	Due to  3c. If yes, out 1 Live b 4 Pregr 9 Unknown tributing to do  28a. Date (Mon 28e. Place buildi  sician: To the ear: On the b and man	(or as a consection of pregning the 2 Fetiliant at time of cown eath but not residue) finjury th, Day Year) of Injury - At hing, etc. (Specials of examinates asis of examinars stated.	quence of):  lancy al death 3 [ death 5 [ sulting in the u  28b. Time or Injury  loome, farm, str	nderlying cau  at 3 DOA  at 286  M  reet, factory, 6	26. Other: 4 c. Injury at Work? 1 Yes office	Place of De Nursing 2 No	Home 28d. 28f.	1 Yes  24a. Was an autopsy perform 1 Yes 2: neck only one 5 Resider Describe how Location (Strictly or Town, due to the caut the time, date	ed?  ed?  No  nce 6 [ State)  use(s) ard plee and  Month contribe No 3 24b. We pricedea 1  Other occurred	ute to th Proba pre autopor to condith? Yes (Specify) or Rural	Day Year  e cause of death ably 4 2 Unkr  psy findings ava inpletion of cause 2 No  Route Number, ated. the cause(s)		
led in by the funeral director, page 2 should be detached for use as the bur Certification: To Be Completed by Physician/Medical	P 2	any, leading to immediate ause. Enter Underlying ause. Enter Underlying ause. (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 33b. Was decedent pregnant in the past 12 months? 1	ical Handing astigation ald not be ermined	Due to  3c. If yes, out 1 Live b 4 Pregr 9 Unknown tributing to do  28a. Date (Mon 28e. Place buildi  sician: To the ear: On the b and man	(or as a consection of pregning the 2 Fetiliant at time of cown eath but not residue) finjury th, Day Year) of Injury - At hing, etc. (Specials of examinates asis of examinars stated.	quence of):  lancy al death 3 [ death 5 [ sulting in the u  28b. Time or Injury  loome, farm, str	nderlying cau  at 3 DOA  at 286  M  reet, factory, 6	26. Other: 4 c. Injury at Work? 1 Yes office	Place of De Nursing 2 No	Home 28d. 28f.	1 Yes  24a. Was an autopsy perform 1 Yes 2: neck only one 5 Resider Describe how Location (Strictly or Town, due to the caut the time, date	ed?  ed?  No  nce 6 [ State)  use(s) ard plee and  Month contribe No 3 24b. We pricedea 1  Other occurred	ute to th Proba pre autopor to condith? Yes (Specify) or Rural	Day Year  e cause of deatl ably 4 2 Unkr  osy findings ava npletion of cause 2 No  Route Number,	

State of Maryland / Department of Health and Mental Hygien 2005 2828 1 - For Stete Registre Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** GERALDINE 16:35 PM HOOVER AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITY HOSPITAL BALTIMORE THE JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) October 13, 1942 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Days Hours 217-38-4370 62 Director ΜĎ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show treumatic event. The Medical Examiner hast be notified at 1 ☐ Yes 2 XNo Ranchester Sheridan Completed by Funeral Director WY. the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 82839 189 Wolfcreek Road Items 23e Pages 1 and 2 should be filed within 72 hours after death inent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "neture!, or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own HOme Housewife 9 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Josephine Graleski Peter August 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 189 Wolfcreek Road, Ranchester, WY, 82839 Larry G. Hoover other 20b. Place of Disposition (Name of cemetery, crematory or other place) August 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5 permit. Page Department of Importent: If eny injury or once. Bayview Crematory | 30,2005 | Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licensee 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease of complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER NON SMALL CELL YEARS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to [or as a consequence of] Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ō Day 4 Pregnant at time of death 5 Other (specify) signed by the al o. 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? THROMBOSIS 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown YEIN 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes → No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 - Homicide within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18606 AUGUST 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALVA, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE ST, BALTIMORE, MD 21287 31. Date filed (Month, Day, Year) State AUG 3 0 2005 Registra

			For State	State of Ma	iryland / Dep	artment of H			71111	5 28282
			Registrar  1. Decedent's Name (First, Middle,	l ast)	Ce	runcate or t	Dealii	2. Date of Dea	189. 110.	3. Time of Death
	Physicia		Charles	John		Hovt		Month		ear
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, or	r Location of De		4c. County of [	
	LXamiii	CI	Riverview Nursi	ng Home		Essex			Balti	more
	Funeral			6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Birt (Month, Day	h 9.	Birthplace (State or Foreign Country)
	Director		216–18–4746	1XM 2□F	81 Yrs.	Morning Bays	110010	March 6	,1924	MD.
	and		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	ocation		<del></del>		10d. Inside City Limits
	f sho	ō	MD Baltim	ore	Dundal.	k				1 ☐ Yes 2 【XNo
	the routil	rec	10e. Street and Number	ore	Durdar	10f. Zip Code			10g. Citizen of Wha	t Country?
	h with	Funeral Director	6945 German Hill	Road		212	22		USA	
	deat	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No-	14. Race - A	American Indian, Vhite, etc.
36	or it	y Fu	1 Never Married 2 Marrie	d 1 X Yes 2 □ N If Yes, Give	lo	1 ☐ Yes 2 💆 No	Specify:	, , , , , , , , , , , , , , , , , , , ,		White
21215-0036	be filed within 72 hours after death with the Manyland Hygiene. id other than "natural", or itema 23a or 28a-f show do ther than "natural", or itema 23a or 28a-f show event, the Medical Examiner investing the motified at	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:		dent's Usual Occup	ation		16b. Kind of Busin	
75	in 72 "na" r	Completed	(Specify only highest	grade completed)	(Give	kind of work done of DO NOT use retired	during most of	working		: City Fire
212	iene.	шo	Elementary/Secondary (0-12) 10 years	College (1-4or 5	Line:	man				partment
פַ	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, L	ast)	· · · · · · · · · · · · · · · · · · ·			Name (First, Middle,		
/lai	2 should be and Mental is marked a	To	Charles Henry Ho	yt			.Ka	therine K	riss	
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationsh					Rural Route Numbe		
ď	ss 1 and 2 of Health litem 27 I		Julianna Casper  20a. Method of Disposition	niece	20b. Place of Dispo		у Ртасе	Apt 201	, ESSEX,	
Baltimore,	permit. Pages 1 Department of H important: If ite any injury or ot		1 ☑ Burial 2 ☐ Cremation		cemetery, cre	matory or other plac		ıgust 29,		
들	artme artme ortant injury		'4 Donation 5 Other (Sp 21. Signatule of Funeral Service L			ary Cemete		2005	Dundalk,	
Ba	Depa Impo any ir once		Inthon	4 (An	nelly of	onnelly Fi 110 Solle	uneral rs Poin	Home Of D it Road, D	undalk,P. undalk.Md	A. 21222
			23a. Part1. Enter the disease, or a shock, or heart failure. List d	omplications that caused						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PHOS		2m(04,				Onset and Death
	/Medical		resulting in death)	a	a consequence of):		0	th 1500 Meta	staris	0000
	Examiner		Sequentially list conditions,	b						
.7	Sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
V	be executed icien and burial-transit	хап	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
8760,	cate be ex physicien the buria	dicai E		d						
9	g phys as the			0.						
Вох	the death certificate y the attending phys iched for use as the	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		⊒Ectopic pregnancy	,		23d. Date of	
-	ie deat the att hed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Other (specify)			Month	Day Year
P.0	that the de ed by the detached	Physician/Me	9 Unknown Part II. Dther significant condition				an in Oast I	OSO Did to	haasa usa saatsibus	te to the cause of death?
	Se GB	i by	Deman	tia.	A	, ,		. 1		Probably 4 Honknown
Records,	w require been sign	Completed		5, ,	/),			24a. Was		
Rec	e las has	dm						<ul> <li>autop perfor</li> </ul>	sy prior deat	
Vital	ician: Th certificate rector, pag	e Co	25. Was case referred to medical				26 Place of I	1 ☐ Yes  Death (Check only o	25 No 1 0	Yes 214No
5		0	examiner?	Hospital: 1  Inpatie	nt 2 ☐ ER/Outpatie	nt 3 DOA Oth	- 4	g Home 5□ Resid		Specify)
10	ng Phys ter this neral di	Ju: T	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o	of 28c. Injun Worl			now injury occurred	
Sion	Attending F r death. ector: After by the funera	atic	2 ☐ Accident investiga	ation			Yes 2 □ No			
Division of	A - 9 Q	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury · At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	pital ours a serai Dilled i	Ce	29a. Certifier 19 Certifying	Physician Tathahari	st and transition days	the account of the size		and due to the		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical	(Check only 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	or my knowledge, deal examination and/or in ted.	in occurred at the tin extigation, in my o	pinion, death o	ccurred at the time,	date and place, and	due to the cause(s)
	To the within 2. To the I complete	Me	29b. Signature and title of certifier	4.0		29c. License	e number	200	29d. Date signed (M	fonth, Day, Year)
			D 1145	V( ·J)		1 2-	-38	154	08-2	-6-2005
	10		30. Name and address of person w	no completed cause of d	eath (Item 23a) (Type	Print) BAS	TERN	1 BLUD	MD	-21221,
	Sta Registr		31. Date filed (Month, Day, Year)	0 2005 32. Registra	ar's Signature	Sparle	, , , , , , , , , , , , , , , , , , , ,			or as stated. due to the cause(s)  fonth, Day, Year)  6 - 2-0-0-5

		1- For State of Maryland / De Registrar	epartment of Health and M Certificate of Death	lental Hyg	iene 2005	28283
		Decedent's Name (First, Middle, Last)		2. Date of Death	h Day Year	3. Time of Death
Physic /Med		Harold J. Hook, III		Aug 2		9:00 A M
Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
		2135 Clearview Drive  5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Owings  (av) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Calvert 9. Birt	hplace (State or Foreign ountry)
Funeral Director		041 64 0449 XX 44 Yrs	Months Days Hours Min.	(Month, Day, Jan 9.		
P		Usual Residence of Decedent	ul anatina			10d. Inside City Limits
shov	5					1 □ Yes 2 □ No
the N 28e-f	ect	Maryland Calvert Ow	ings 10f. Zip Code	11	Og. Citizen of What Co	
3e or	ū	2135 Clearview Drive	20736		United Sta	tes
d 21213-90036  filed within 72 hours after death with the Maryland Hygiene.  ther than "natural" or Items 23e or 28e-f show ant, the Medical Ever it with mast be redified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spo If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
or lite	y Fu	1 ☐ Never Married XX Married 1 ☐ Yes 2 XX No	1 ☐ Yes 2☐ No Specify:	, , , , , , , ,	Specify.Whi	·
tural,	q pe	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. D	ecedent's Usual Occupation		WN1 16b. Kind of Business/	
n ne	Completed	(Specify only highest grade completed)	Give kind of work done during most of work fe. DO NOT use retired)	ing		
d 212 filed withi Hygiene. other than	mo.	Elementary/Secondary (0-12) College (1-4or 5+) 12 Mas	ter Electrician		Constru	ction
0 9	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		Maiden Sumame)	
larylan( 2 should be i and Mental   1s marked o aumatic eve	2	Harold John Hook, Jr.	Mirial  Mailing Address (Street and Number or Run	m Smith	City Tarres Chair	71- 0-1-1
Baltimore, Maryland 21215-0035 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or any injury or other traumatic event, the Medical Energians in the Medical Energians.		, , , , , ,	35 Clearview Drive,			in Code)
re, s 1 an Heal Heal		20a. Method of Disposition 20b. Place of Disposition	risposition (Name of crematory or other place) Aug 31,		20c. Location - City or	Town, State
Pages nent of int: If it		1 Dullar 2 Coloniation o Enternovarion State	ection = Cemetery	2003	Clinton, M	aryland
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any injury or other	i i	21. St nature of Funeral Service Licensee	22. Name and Address of Facility $Lee$	Funeral	Home, Inc	6633 01d
<b>n</b> 8255	12	Machel Hances Storling MO1435	Alexandria FerryRd	, Clinto	n, MD 207	35
L		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
Priysician /Medica		Immediate Cause (Final disease or condition resulting in death)	organ Facher	0		
Examine		Due to (or as a consequence of	atic Color	n CF	+	
	Je.	Sequentially list conditions, if any, leading to immediate course. Each lader wing.	:			
68760, Circate be executed physician and is the burial-transit	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events c.				
8760, ate be exe hysician a the burial-	EX	resulting in death) Last Due to (or as a consequence of)	:			
3876 icate to physical	dicai	d				
Records, P.O. Box 68760, ~  The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burfal-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	.50		23d. Date of de	livery
Geath death e attended for a	icial	in the past 12 months?  4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
IS, P.O. I	hys	9 Unknown				4
S, Les the rigned be de	by	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tot	pacco use contribute to es 2 □ No 3 □ Pr	o the cause of death?
cord w require been si	eted	7.6 52/10-(1.11)		24a. Was a		
Rec ne law s has l	Completed			autops	ned?   death?	utopsy findings available completion of cause of
tal an: Ti tificate or, pa		25. Was case referred to medical	26. Place of Deat			i 2□ No
f Vi yslcie is cer direct	To Be	examiner?	Other		ence 6 Other (Spe	cify)
ng Ph fter th		27. Manner of Death 28a. Date of Injury 28b. Tir	ury Work?	28d. Describe ho	w injury occurred	
isio ttendii death. stor: A the fu	cati	Accident investigation	M 1 Tyes 2 No	20f Location (St	reet and Number or R	um/ Pouto Number
Division of Vital Records, for Attending Phystcian: The law requires thater death.  Director: Atter this certificate has been signed in by the funeral director, page 2 should be	Certification;	4 Homicide  4 Homicide  4 Succeeding the could not be determined  4 Succeeding the could not be determined building, etc. (Specify)	n, street, factory, office	City or Town	n, State)	arar Houte Humber,
Hospitel 24 hours a Funeral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge,				
Division of Vital Rec To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/one)  and manner stated.	or investigation, in my opinion, death occur	red at the time, d	ate and place, and due	e to the cause(s)
To the within 2. To the complet	Σ	29b. Signature and title of certifie	29c. License number		9d. Date signed (Mont	th, Day, Year)
			743636		8/2	7103
6		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) Marlbon	MP	20773	)
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regis		AUG 3 0 2005	Sicili)			

State of Maryland / Department of Health and Mental Hygiene 2005 28284 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:21 PM **Physician** HOKENSUN 2005 EDNIT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1-10Spital Be thes de Monts burban If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1 □ M 2 🔽 F 473 03 8362 87 10, Nov Wadena, Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f show The Medical Examinar must be notified at Maryland 1 Yes ZNNo Montgomery Bethesda Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5821 Bradley Blvd. 20814 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 Yes 2 Tho Widowed 4 □ Divorced Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Micro biologist Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental ant: If item 27 is marked o William Arndt Laura Struck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Erdahl (Niece) 4608 Aldrich Ave So. Mpls 55419 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐X emation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Lee Crematory Aug 28, 2005 Clinton, MD 21. Signatur of Junera San 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Rd, Clinton, MD 20735 20015 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC TUMOR TO LUNES, BONE, LIVER **Physician** /Medical Due to (or as a consequence of): Examiner CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🔲 No 1 Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) PVOutpatient 3□ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct comple ely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RILO WOODMONT HUE SUITE 20, Bethes de 1814 JANE H. CHRETIEN, MO 31. Date filed (Month, Day, Year) 32. \*\* trar's Signature State Registrar

DHMH 17 Rev 1/2001

8/36/05/172

tokension, Edna

			1 - For State Registrar	Clair of Mary	Cei	rtificate of	Death		leg. No.	28283
	Physici		Decedent's Name (First, Middle     LILLIAN	, Last)		HARR	ELL	2. Date of Dea AUGUST	<sup>th</sup> 24 2005	3. Time of Death 5:25 A M
	/Medio Examir Funeral		4a. Facility Name (If not institution STELLA MARIS H	OSPICE  6. Sex 7. Age (In )	yrs. last birthday)	4b. City, Town, o	TIMONIU	M 8. Date of Birth	4c. County of Do	BALTIMORE Sirthplace (State or Foreign
	Director		Usual Residence of Decedent  10a. State  10b. County	/4	Yrs.			02/17/19	931′	MD  10d. Inside City Limits
	he Maryla 88-f shov	Director	MD BALT		REISTERS	STOWN				1 ☐ Yes 2 No
	ath with the 23a or 2	rai Dir	302 CANTADA CO			10f. Zip Code 21136			U.S.A.	
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic evant, The Marical Examine Instituted at	d by Funerai	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces?  ed 1 Yes 2 No If Yes, Give Year or Dates:	I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	Black, W	nerican Indi <i>a</i> n, hite, etc. HITE
7-6171	within 72 h ene. than "natu	Completed	15. Decedent (Specify only highes) Elementary/Secondary (0-12)		life.	dent's Usual Occup kind of work done o DO NOT use retired FERIOLOGI	d)	rking	16b. Kind of Busines PATHOL(	
מופו	should be filed within of Mental Hygiene. markad othar than imatic evant, III.e M.	To Be Co	17. Father's Name (First, Middle, I	Last)	SACH			me (First, Middle,		LEVY
, Mai y	and 2 should leath and Men n 27 is marka			DAUGHTER	111	EAST CHA		AVEREI		MD 21136
altillore	permit. Pages 1 Department of H Important: If itan any Injury or ott once.		20a. Method of Disposition 1 💢 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 □Removal from State Decify)	BETH JACO	natory or other place OB CONG.	08/2	6/2005	FINKSBURG	MD
מ	permit. Pag Department Important: It any Injury o		21. Signature of Funeral Services	Stillman	89	000 REIST	ERSTOWN	ROAD - P		MD 21208
	Physician /Medical Examiner		26a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	e S	er the mode of dyin	g, such as cardiad	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	100	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Ir july that initiated events resulting in death) Last	b						
00/00,	ficate be physicials to the bur	Medicai		d						
.O. DOY	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 of 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of o	lelivery Day Year
i con	equires that en signed b ould be deta	by	Part II. Other significant condition	rescontributing to death bot not	resulting in the u	nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 □Unknown
מטטע וו	The law recate has be-	Completed	Refractory	Nbn-Hod	gkinis	lymp	homa	24a. Was a autops perform	sy prior t	
טוו טו אוגמו	To the Hospital or Attanding Physician: The law within 24 buouts after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ion; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Matural 5 ☐ Pendin	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	f 28c. Injun Work	er: 4 Nursing H y at k?		ence 6 □Other (Spow injury occurred	pecify)
	ial or Attanc is after death al Diractor: ad in by the f	Certification;	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	ot be 280 Place of Injune	At home, farm, str pecify)		Yes 2 □ No	28f. Location (St City or Town	treet and Number or n, State)	Rural Route Number,
	ha Hospil in 24 hour ha Funare	edicai	29a. Certifier 12 Certifyin (Check only one) 1 Medical I	g Physician: To the best of my Examiner: On the basis of exam and manner stated.	knowledge, death	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	a, and due to the carried at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	Time Won	ght, w	29c. Licens	e number 5 2 7 4	-0	9d Date signed (Mo	24th 2005
1	7		30. Name and address of person	who completed cause of death	(Item 23a) (Type,	Print)			J	

State Registrar 31. Date filed (Month, Day, Year) AUG 3 0 2005 32. Pegistrar's Signature

ERNESTINE WRIGHT, M.D.

AUGUST 24, 2005

2300 DULANEY VALLEY ROAD

TIMONIUM

MD

21093

			1 - For State Registrar	State o	f Maryland / I	Depa <i>Cei</i>	artment of Hortificate of L	ealth and M Death	lental Hygid	200	5 2	28286
		П	1. Decedent's Name (First, Middle, Last						2. Date of Death	Day	Year	3. Time of Death
	Physici /Medi		Carylon J	ane Joh	nson				Month Aug. 20	5, 2005		2:11 pm <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death		4c. County	of Death	
			Souther Maryland					Maryland		Prince		
	Funeral Director		5. Social Security Number 6. Se 231–72–2370	х Эм 2 <del>X</del> ДF	7. Age (In yrs. last bi 54	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 16		Countr	ce (State or Foreign y) ry Virgini
	pun *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tow	en or Lo	cation				10	d. Inside City Limits
	fanyla faho e a ut	5		Coordos							100	1 X Yes 2 ☐ No
	28a-	Director	MD Prince  10e. Street and Number	GCOLGC	1010 //	a.D.	10f. Zip Code		100	J. Citizen of What Country?		v?
	3a or			1.0			20744		S. A.			
	ms 2	Funeral	206 Woodgreen Circ	12. Was Dece	edent Ever in U.S.	13.	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Race	- American	
36	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f ahow adical Examiner must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Fo 1 [] Yes If Yes, Giv Year or D	2 XNo		f Yes, specify Cubar 1 □ Yes <b>2</b> No	Specify:	Hican, etc.)	Specify:	c, White, et Blac	
Ö	2 hou	ted	15. Decedent's Edi		16a		lent's Usual Occupa		16	b. Kind of Bus	siness/Indu	ıstry
21215-0036	C 2	Completed	(Specify only highest grade   Stephentary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work done d DO NOT use retired)	)	mg			
5	tyg Tha		17. Father's Name (First, Middle, Last)		Di	sab.	led	18 Mother's Name	e (First, Middle, Ma	n/a	a.)	
Maryland	o d a b	o Be						Alice (		adon Damama	-/	
Ž	s 1 and 2 should if Health and Men itam 27 Is marke other traumatic	T <sub>O</sub>	Robert Motton  19a. Informant's Name/Relationship (T)	rpe, Print)	198	o. Mailir	ng Address (Street a			City or Town, S	State, Zip C	>ode)
	1 and 2: Health ar tam 27 Is	10	Charlotte Motton-K	elly/da			llison Su			-		
Je,	s 1 a		20a. Method of Disposition	<del>_</del>	cometa	of Dispo	sition (Name of natory or other place	e) (A -	Date 20	c. Location - (	City or Tow	m, State
ij	Pages ment of I ant: If its ury or o		1 XBurial 2 □ Cremation 3 □ I  1 4 □ Donation 5 □ Other (Specify,		State		Baptist C	hurch Cen	netery S	eptembe		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	99	4.	22	. Name and Addres	s of Facility $ $	atney's E			
_	207 2 2		Jalph Wells	amo			8831 Georg				2001	.1
		ķį.	23a. Part1. Erfter the disease, or comp shock, owneart failure. List only of	lications that c ne cause on e	aused the death. Do ach line.	not ent	er the mode of dying	g, such as cardiac	or respiratory arrest	t,	10	Approximate nterval Between Onset and Death
	Physician	0.0	Immediate Cause (Final disease or condition resulting in death)	a *	SEPSI	5						
	/Medical Examiner		Tooding in doubly	Due to	or as a consequence	of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a consequence	of):						
	uted d ansit	Examiner	cause. Enter Underlying that initiated events	2								
oʻ	an an rial-tr	Exa	resulting in death) Last	Due to (	or as a consequence	of):						
8760,	cate be executed physician and the burial-transit	dical		d								
9	entific ling p	Mec	IF FEMALE:	20 - 16								
Вох	eath certifi attending ( for use as	Physiclan/Me	in the past 12 months?	1 Live b	come of pregnancy inth 2 Testal death		Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th D	/ Pay Year
o.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno	ant at time of death	3 L	Other (specify)					
<u>α</u>	th de		Part II. Other significant conditions co	ntributing to de	eath but not resulting	in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contri	bute to the	cause of death?
of Vital Records,	quires in sign uld be	ed by			STROL	Œ			1 🗌 Yes	2 □ No :	3 🗌 Probab	oly 4 🖄 Unknown
000	aw require s been siy 2 should k	Completed							24a. Was an			sy findings available
R	The law cate has page 2.	шо							autopsy performe 1 Yes 2	d? de	or to comp eath? ☐ Yes 2	oletion of cause of
ita		BeC	25. Was case referred to medical examiner?					26. Place of Death	(Check only one)			
<u>&gt;</u>	dis dis	To	1 ☐ Yes 2 No	fospital: 1 💢	npatient 2 ER/O	utpatien	t 3 DOA Othe	r: 4 ☐ Nursing Ho	me 5 ☐ Residend	e 6 Othe	r (Specify)	
U	ing Ph After th uneral	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date (Mont		Time of Injury	28c. Injury Work	?	28d. Describe how	injury occurre	d	
Sio	tend death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	00 - Di	- Claires Athana 6			′es 2□No	Opt Laurtine /Char	A manuf Advance	O 1 (	2
Division	ial or Attending s after death. al Diractor: After ed in by the fune	Certification:	4 ☐ Homicide determined	buildi	of Injury - At home, fang, etc. (Specify)	arm, str	eet, ractory, office		28f. Location (Stree City or Town, S		r or murai r	noute ivamber,
	in and in the state of the stat	edical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the	best of my knowledg asis of examination ar	e, death	occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and man	iner as stat nd due to th	ed. he cause(s)
	To the Hos within 24 h To the Fun completely						29c. License	number	29d	. Date signed	(Month, Da	ay, Year)
	- 3 F 8		A 200 12	W/			Dac	150	A	UC 28	2.70	101
	DY		30. Name and address of person who c	ompleted caus	e of death (Item 23a)	(Туре.	Print)	134		-4 ~0		
	′′) `		29b. Signature and title of certifier  30. Name and address of person who ce Siscim OSIA, G19  31. Date filed (Month, Day, Year)  AUG 3 0 2	IZ OX	IN HILL	Ro	MD # 721	O DRON	HILL 1	NO :	1074	45
	Sta	ate	31. Date filed (Month, Day, Year)	32.	egistrar's Signature	A	ments.					
	Regist	rar	AUG 3 0 2	ana	CHECKIN NO	2						

Physicia	an	1. Decedent's Name (First, Middle, L Lleen T			Certificate of		2. Date of Dea	_Dav Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, g	ickson		4h City Town o	r Location of Death	08 2	4c. County of Death	1:49 P
Examin	er	219 East Lafayet				timore		le soun, or soun	
uneral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last birt	hday) If Under 1 Year Months Days		B. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Forei
rector		219-40-3259	1□M 2 <b>1</b> 2F	62	Yrs.	110010	04/30/19		land
be filed within 72 hours after death with the Maryland tal Hyglene. id other than "natural", or itams 23a or 28a-f show other than "natural", or itams 23a or 28a-f show event. The Madical Examinat must be notified at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location				10d. Inside City Limi
fled	tor	Maryland		F	Baltimore				1∭Yes 2☐N
be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
Examiner must b	rail	219 E. Lafayette	· ·		2120			U.S.A.	
	une	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	
	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XI If Yes, Give Year or Dates:	NO	1 ☐ Yes 2 【XNo	Specify:		Specify: B]	Lack
	ted	15. Decedent's	Education	16a.	Decedent's Usual Occup (Give kind of work done	ation	_   1	6b. Kind of Business/l	ndustry
	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NOT use retired	during most of working 1)	9		
1	Con	9			Housewife			Homemake	er
8	Be	17. Father's Name (First, Middle, Las	st)			18. Mother's Name		faiden Sumame)	
g P	ပ္	Charlie Barr		10h	Mailing Address (Street	Edna Cole		City or Tour State 7	in Code)
		Diane Oloughlin /			-			·	
		20a. Method of Disposition		20b. Place of	9 East Lafa Disposition (Name of y, crematory or other place)	yette Ave.	ite 2	no Te , Mary Oc. Location - City or	land 212( lown, State
		1 X Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spæ			lem. Pk. Cem		/2005 B	Baltimore.	Maryland
9		21. Signature of Funeral Service Lic	<del>\                                    </del>		22. Name and Addre	ss of FacilityThe I	errick	C. Jones F	'/H, P.A.
QUCE.		Della	1:		4611 Park H				
cal ner	Iner	resulting in death)  Sequentially list conditions, if any, leading to immediate	b.	a consequence o					
	xam	Sequentially list conditions, if any, leading to immediate cause. Enter Underthing Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence o					
	edical Examiner	that initiated events	c. Due to (or as	a consequence o					
or use as i	cai	that initiated events	d23c. If yes, outcome	of pregnancy	of):	=		23d. Date of deli Month	very Day Year
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Ves} \) 2 \( \text{No} \)	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal death time of death	3 □Ectopic pregnancy 5 □ Other (specify) □		23a. Did toba		Day Year
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal death time of death	3 □Ectopic pregnancy 5 □ Other (specify) □			Month	Day Year the cause of death?
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal death time of death	3 □Ectopic pregnancy 5 □ Other (specify) □		1 ☐ Yes	Month  acco use contribute to  s 2 \[ \text{No} 3 \] \text{Pro}	Day Year the cause of death? bbably 4 Unkno
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal death time of death	3 □Ectopic pregnancy 5 □ Other (specify) □		1 Yes	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Prc} \) Pro	the cause of death?  bably 4 Unkno
	e Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal death time of death	3 □Ectopic pregnancy 5 □ Other (specify) □		1 Yes  24a. Was an autopsy perform 1 Yes 2	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) Pro  24b. Were aut prior to c death? \( \text{death} \) 1 \( \text{Yes} \)	Day Year the cause of death? bbably 4 Unkno
•	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	23c. If yes, outcome 1	of pregnancy 2 Fetal death time of death ut not resulting in	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ☐ the underlying cause given the underlying given the underlying given the underlying cause given the underlying giv	en in Part I.  26. Place of Death er: 4  Nursing Hom	1 Yes  24a. Was an autopsy perform 1 Yes 2  (Check only one	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) Pro  24b. Were aut prior to c death? \( \text{death} \) 1 \( \text{Yes} \)	the cause of death?  bably 4 Unknown oppy findings availation of cause of the cause
	To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	23c. If yes, outcome 1	of pregnancy 2 Fetal death time of death ut not resulting in	a DOA  Stpatient 3 DOA  Oth  Time of 28c. Injury Morniyury M 1	en in Part I.  26. Place of Death er: 4 □ Nursing Hom y at 28 k? Yes 2 □ No	24a. Was an autopsy perform 1 Yes 2 (Check only one e 5 Resider ad. Describe how	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) Protection (ed? \( \text{death} \) No \( \text{1 \text{Yes}} \) 1 \( \text{Yes} \) Yes \( \text{violate} \) ince \( 6 \) Other (Special violate) occurred	Day Year the cause of death? bably 4 Unknow topsy findings availat ompletion of cause of 2 No
ימופומו מופלונין. למקס ג פונינול כס נפומניוסנ יכן מסס מט	o Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	23c. If yes, outcome 1	of pregnancy 2 Fetal death time of death  ut not resulting in  ent 2 ER/Out ry y Year) 28b. T	a ⊟Ectopic pregnancy 5 ☐ Other (specify) ☐  the underlying cause give  tpatient 3 ☐ DOA Other  Time of 28c. Injury	en in Part I.  26. Place of Death er: 4 □ Nursing Hom y at 28 k? Yes 2 □ No	24a. Was an autopsy perform 1 Yes 2 (Check only one e 5 Resider ad. Describe how	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) Pro  ced?  \( \text{No} \) 1 \( \text{Yes} \) yes  ce 6 \( \text{Other} \) (Spec  w injury occurred	Day Year the cause of death? bably 4 Unknow topsy findings availat ompletion of cause of 2 No
	edical Certification; To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	d.  23c. If yes, outcome 1	of pregnancy 2 Fetal death time of death  ut not resulting in  port 2 ER/Out ry y Year 28b. T ir ury - At home, far c. (Specify)  of my knowledge f examination and	a DOA  Stpatient 3 DOA  Oth  Time of 28c. Injury  M 1	26. Place of Death  er: 4 \sum Nursing Hom  y at 26  X?  Yes 2 \sum No	24a. Was an autopsy perform 1 Yes 2 (Check only one e 5 Resider 3d. Describe how 3f. Location (Stree City or Town, and due to the caud at the time, dat	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) Provided?  acco use contribute to to s 2 \( \text{No} \) 3 \( \text{Pro} \) Provided?  acco use contribute to to death?  24b. Were authorized to death?  1 \( \text{Yes} \)  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  24b. Were authorized to death?  1 \( \text{Yes} \)  24b. Were authorized to death?  24b. Were authorized to death.  24b.	the cause of death?  shably 4 Unknow  sopsy findings availated  ompletion of cause of  2 No  ify)  ral Route Number,  stated, to the cause(s)
Tuneral director, page z snould be detached for use as t	Certification; To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending investigat 3  Suicide 6 Could not determine  29a. Certifier 1 Certifying 1  29a. Certifier 1 Certifying 1  29a. Certifier 1 Certifying 1  20 Medical Ex	d.  23c. If yes, outcome 1	of pregnancy 2 Fetal death time of death  ut not resulting in  port 2 ER/Out ry y Year 28b. T ir ury - At home, far c. (Specify)  of my knowledge f examination and	al Ectopic pregnancy  5 Other (specify)  the underlying cause give  the und	en in Part I.  26. Place of Death er: 4 \sum Nursing Hom y at 28 k? Yes 2 \sum No  26 ne, date and place, ar pinion, death occurred e number	24a. Was an autopsy perform 1 Yes 2 (Check only one e 5 Resider 3d. Describe how 3f. Location (Stree City or Town, and due to the caud at the time, dat	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) Provided?  acco use contribute to to s 2 \( \text{No} \) 3 \( \text{Pro} \) Provided?  acco use contribute to to death?  24b. Were aut prior to c death?  1 \( \text{Yes} \) 9  acco death?  1 \( \text{Yes} \) 1 \( \text{Yes} \) 9  acco death?  1 \( \text{Yes} \) 1 \( \text{Yes} \) 9  acco death?  1 \( \text{Yes} \) 1 \( \text{Yes} \) 9  acco death?  1 \( \text{Yes} \) 1 \( \text{Yes} \) 9  acco death?  1 \( \text{Yes} \) 1 \( \text{Yes} \) 9  acco death?  1 \( \text{Yes} \) 1 \( \text{Yes} \) 9  acco death?  1 \( \text{Yes} \) 1 \( \text{Yes} \) 9  acco death?  1 \( \text	the cause of death?  the bably 4 Unknow  topsy findings availated on the cause of t
on the runeral bractor. After this certificate has been signed by the attending prysicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Certification; To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	d.  23c. If yes, outcome 1	of pregnancy 2 Fetal death time of death  ut not resulting in  port 2 ER/Out ry y Year 28b. T ir ury - At home, far c. (Specify)  of my knowledge f examination and	al Ectopic pregnancy  5 Other (specify)  the underlying cause give  the und	en in Part I.  26. Place of Death er: 4 \sum Nursing Hom y at k? Yes 2 \sum No	24a. Was an autopsy perform 1 Yes 2 (Check only one e 5 Resider 3d. Describe how 3f. Location (Stree City or Town, and due to the caud at the time, dat	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) Provided?  acco use contribute to to s 2 \( \text{No} \) 3 \( \text{Pro} \) Provided?  acco use contribute to to death?  24b. Were auliprior to c death?  1 \( \text{Yes} \)  1 \( \text{Yes} \)  24b. Were auliprior to c death?  1 \( \text{Yes} \)  1 \( \text{Yes} \)  25c.  4 \( \text{Injury occurred} \)  4 \( Provided of the results of	the cause of death?  the cause of death?  bably 4 Unknown  topsy findings availal completion of cause of  2 No  ify)  ral Route Number,  stated. to the cause(s)

		1 - For State Registrar	State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygie Reg.	2005 282	88
Physic /Med		Decedent's Name (First, Middle, Last, Lula	Mae	Joyner	2. Date of Death Month August	Day Year	of Death
Exami		4a. Facility Name (If not institution, give Gilchrist Nursi		4b. City, Town, or Location of Death TOWSON		4c. County of Death Baltimore	- I
Funera Director		5. Social Security Number 6. Security Number 243-50-2740 Usual Residence of Decedent	7. Age (In yrs. last birthday 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 06 06	9. Birthplace (State Country) NC	or Foreign
death with the Maryland me 23a or 28a-f show	tor	10a. State 10b. County  MD NA	10c. City, Town or L Baltim			10d. Inside	City Limits
with the a or 28s	Direc	10e. Street and Number	ichta Avo	10f. Zip Code 21207	10g.	Citizen of What Country?	
72 hours after death natural', or Iteme 23	by Funeral Director	5609 Liberty He  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	acify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
within ene. then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 6th grade	College (1-4or 5+)  (Given life.	adent's Usual Occupation e kind of work done during most of worki DO NOT use retined) Domestic	ng	Kind of Business/Industry	
ild be filed fental Hygi rked other	To Be (	17. Father's Name (First, Middle, Last)  Micheal Moody		18. Mother's Name Oria Sq	(First, Middle, Maid uire	den Sumame)	
permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c any injury or other traumatic eventors.		19a. Informant's Name/Relationship (Ty Lee Moody-Son  20a. Method of Disposition  XXSurial 2 □ Cremation 3 □ R	5609  20b. Place of Disp cemetery, cre	Liberty Height osition (Name of productory or other place)  Ridge 9/2/	s Ave, E		
permit. Pa Departmen Important any injury		21. Signature of Funeral Service License 23a. Part1 Enter the disease, or complishock, or heart failure. List only or	Jumpson M Gations that caused the death. Do not er	2. Name and Address of Facility arch F/H West 300 Wabash Ave,	Baltimo		. 5 ate etween
The law requires that the death certificate be executed	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	of Right Ten	POTAL B	UVVIA	
ires that the death certific signed by the attending p d be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
quires that t an signed by uld be deta	by	Part II. Other significant conditions cor	tributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of 2 No 3 Probably 4 □	
sician: The law requ certificete has been lirector, page 2 shoul	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 ☑		available cause of
Phy ral d	atlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No H  27. Manner of Death 1 ☒ Natural 5 ☐ Pending investigation	ospital: 1 Inpatient 2 ER/Outpatie  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		Check only one) ne 5 Residence 28d. Describe how in		ø i Ce
to the Hospital or Attending within 24 hours after death. to the Funeral Director: After completely filled in by the fune fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Sta		nber,
the Hosp thin 24 hou the Fune mpletely fil	Medical	(Check only one)    X Certifying Physical Examination   Check only one   Check o	ician: To the best of my knowledge, dear ner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurre	ed at the time, date a	ind place, and due to the cause(	s)
		> M Arthon	mpleted cause of ath (Item 23a) (Type,	29c. License number D25205  Print) Charles St. Bal		Date signed (Month, Day, Year)	5
3 St	ate	WARILLY G 31. Date filed (Month, Day, Year)	32. <b>Fe</b> gistrar's Signature	Charles St. Bal	to mel.	2,20%	
Regist		AUG 3 0 201		north			-

			State of Maryland / Departme  1 - State	nt of Health and Me	ental Hygier	
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Harvey F. Johnson		Month 0	7 2005 21:33p. <sup>M</sup>
>	/Medic Examin			y, Town, or Location of Death		4c. County of Death
				ilto		N/A
	Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Und Months  216-40-1072 74		8. Date of Birth (Month, Day, Yes 3-31-193	
	pu k		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
	Aanyla I sho	ö	Md N/A Balto			1X Yes 2 No
	the N 28a-f	Director		Zip Code	100	Citizen of What Country?
	aa or		3805 Sequoia Avenue	21215		USA
	death	Funeral		edent of Hispanic Origin? (Spec becify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,
39	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Exprairment until be notified at	by Fui	1X Never Married 2  Married	oecity Cuban, Mexican, Puerto F 2	Rican, etc.)	Black, White, etc.  Specify: Black
21215-0036	r2 hou	ted	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of w	sual Occupation work done during most of workin	16b.	. Kind of Business/Industry
2	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	use retired)	9	Unk
7	filed wi Hygien other th		6th grade N/A Security		(Final 18:14)	( (
Maryland	should be filed within ind Mental Hygiene. s marked other than "umatic event, the Mai	) Be	17. Father's Name (First, Middle, Last) Harvey F. Johnson	18. Mother's Name  Edna Cr		en Sumame)
2	2 should and Men is marke aumatic	٦ ک		ss (Street and Number or Rural		ty or Town, State, Zip Code)
	s 1 and 2. of Health ar item 27 is		Barbara A. Sheridan - Niece 3805 Sec	quoia Avenue Ba	alto, Md	21215
altimore,	as 1 a of Hec item rothe		20a. Method of Disposition 20b. Place of Disposition (N. cametary, crematory or	ame of Dar other place)	ate 20c.	Location - City or Town, State
<u>Ĕ</u>	Pages ment of I ant: if its ury or o		1  Burial 2  Cremation 3  Removal from State  '4  Donation 5  Other (Specify)  Mt Carmel Ce	emetery 8-23-	-2005 Ba	alto, Md
Balt	permit. Pages 1 and Department of Heall Important: if item 2 any injury or other once.		21. Signature of Funeral Service Licensee 22. Name :	and Address of Facility Ma 4300 Wabash		West Balto, Md 21215
١,	•		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(asdeal )	marca	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):	1 5	- 1	
П	Examiner		Suggestially list conditions, b Coronacy &	telegy 1	ese a	10
7	sit ad	Examlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0		
V	xecuti and II-tran	хап	resulting in death) Last  Due to (or as a consequence of):			
760,	cate be executed physician and the burial-transit	dical E				
687	ificate g phy: as the	edic	u.			
Вох	h cert endin	M/W	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 □ Live birth  2 □ Fetal death  3 □ Ectopic	prognancy		23d. Date of delivery
P.O. B	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burral-transit	Physiclan/Me	in the past 12 months?  1  Yes 2  No 9  Unknown 9  Unknown 9  Unknown			Month Day Year
	that the by detail	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying	J cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
rds	w requires to been signer should be contact.	Completed by	typestersion		1 🗆 Yes	2 No 3 Probably 4 Unknown
000	s bee	olete	31		24a. Was an	24b. Were autopsy findings available
æ	The lav	mo			autopsy performed 1 ☐ Yes 2 ☐	
ţ	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death		
<u></u>	Physic this ce al dire	To	1 Yes 2 Ho Hospital: 1 Inpatient 2 ER/Outpatient 3 I	OOA Other: 4 Nursing Hom	ne 5 - Projdence	6 ☐ Other (Specify)
D C	ding P. h. After t funera	on:	27. Manner of Death 1 ☐Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury (Month, Day Year) Injury	Work?	8d. Describe how in	njury occurred
Division of Vital Records,	ttend death stor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be determined. 28e. Place of Injury: At home, farm, street, factors.	1 Yes 2 No	Rf Location (Street	and Number or Rural Route Number,
<u>≥</u>	or Attence after death Director:	Certification;	4 Homicide determined building, etc. (Specify)	ny, onice	City or Town, St	
	ospita hours ineral y filler		29a. Certifier Certifying Physician: To the best of my knowledge, death occurre	d at the time, date and place, a	nd due to the cause	e(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.			
	To t To t	Σ		9c. License number	29d. I	Date signed (Month, Day, Year)
,			Itul Useal Mh	N30148		8/23/2005
20-	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AN LUBZHOL AAQ FALL	-s PO BI	ALTO M	nb 21211
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 3 () 2005  32. Registrar's Signature	,		
-			POUR CESOS FERENCE -			The second secon

DHMH 17 Rev 1/2001

Patent known as Paul L Jones Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <

			Please '	Type or Prir					-		_		
	•	For State Registrar		State of Ma	aryland		nent of F <i>cate of</i>		Mental Hy	/giene Reg. N	11115	28290	
25 A.			e (First, Middle, Las	t)					2. Date of D			3. Time of Death	_
Physicia /Medic		Paul I	Jones						Ausust	2,1		- 11:45 AM	1
Examin	2	4a. Facility Name (I	f not institution, give	street and number)		4b	. City, Town, o	or Location of Deat	h	40	. County of Dea	th	
	15	1. 1. 1	Hospital e	1		1	Salta		100 10				
Funeral		5. Social Security N	- 11	X 7. Ag X M 2 ☐ F	e (In yrs. la		Under 1 Year onths Days	If Under 24 Hrs Hours Min.	(Month, D	ay, Year)	C	thplace (State or Foreigi ountry)	п
Director		176-34-72 Usual Residence of			62				May	, 19	743 PE	ennsylvania	-
saryland show		10a. State	10b. County		10c. City,	Town or Location	on					10d. Inside City Limits	
e Ma	cto	MD	Balt	imore	Ow	rings Mi	11s					1 ☐ Yes 21X No	,
or 28	Director	10e. Street and Nur				1	Of. Zip Code			10g. Ci	tizen of What C	ountry?	
e 236	erai		ntrose Ave	enue 12. Was Decedent	Suprin II S	12 14/22	211		Specify Vec or N		U.S.A.	orican Indian	
ter de Item	Funerai	11. Marital Status	ied 2☐ Married	Armed Forces?		If Yes	s, specify Cub	Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	0-	Black, Whi		
titled within 72 hours after death with the Maryland Hygiene. Hygiene. Inther than "natural", or Iteme 23a or 28a-f show out, the Mydical Examination count to confilled.	by	3 Widowed		If Yes, Give Year or Dates:		10	Yes ZK No	Specify:			Specify:	Black	
72 hours "natural"	ted	/Sner	15. Decedent's Ed	ucation		16a. Decedent'	s Usual Occup	pation during most of wo	dena	16b. K	(ind of Business		
ithin ithin	Completed	Elementary/Seco		College (1-4or 5	5+)	life. DO N	VOT use retire	(d)	9				
led w tygier her th		10	(First Middle Lock)				Superv	isor 18. Mother's Nar	ma (Cient Middle		lousekee	ping	
ibe ti ntal H ed ot	Be	17. Father's Name	chard	Gillom					•				
should be nd Mental i marked c	<u>٩</u>		ame/Relationship (T			19b. Mailing Ad	ddress (Street	and Number or Ru		Jone		Zip Code)	_
C1 c2 72 90			Martin	,,,,,,,,,,,,		27 Mon		Avenue C		,		117	
Pages 1 and nent of Health int: If Item 27 iry or other to		20a. Method of Disp	position		20b. Pla	ace of Disposition	n (Name of		Date		ocation - City or		
Page Bent o nt: If ry or			☑Cremation 3 ☐ 5 ☐Other (Specify	Removal from State )	111			Ser 8/30	1/05	На	mostead	, Maryland	
permit. Departir Importa any inju		21. Signature of Fy	Septo Licen	7	0		me and Addre					wn Road	
3 88 8 8		1	MYE	25		E1	ine Fu	neral Hom	ne Re	iste	rstown,	MD 21136	
		23a. Part1. Enter a shock, or hea	he disease or comp rt failure. List only o	lications that caused one cause on each li	the death. ne.	Do not enter th	e mode of dyl	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death	
Physician		Immediate Cause disease or condition resulting in death)		a. Pulmon	ary e	nbolus						2 days	
/Medical Examiner		resulting in death)	(	Due to (or as	a conseque	ence of):							
	er	Sequentially list co	nditions,	b. Due to (or as	а сопеции	arica off							
uted uted	Examin	cause. Enter Under Cause (Disease or that initiated events	injury										
be executed sician and burial-transit		resulting in death)	Last	Due to (or as	a conseque	ence of):						-	
The law requires that the death certificate be extended that been signed by the ettending physician bage 2 should be detached for use as the buria	Physician/Medical			d									
artifica ing pt	Med	IF FEMALE:								-			_
ath co	lan/	23b. Was deceden in the past 12	t pregnant	23c. If yes, outcome 1□Live birth	2 Fetal	death 3□Ecto	opic pregnanc	у			23d. Date of de Month	livery Day Year	
at the de by the e	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4□Pregnant at 9□Unknown	time of dea	atn 5⊟ Otr	ner (specify) _						
res that tigned by		Part II. Other signif	ricant conditions co	ontributing to death b	ut not resul	lting in the under	lying cause giv	ven in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?	
quires n sign	d by	Chronic	obstruct	ve pulmo	nory	disease	hype	descion	1 🗆	Yes 2	□No 3□P	robably 4 Unknown	١
tw requir s been s	Completed	Change	Canal	failur	'	,	- 11	,	24a. Wa		24b. Were a	utopsy findings available completion of cause of	a
The law cate has page 2 s	ome	CALONIC	# 16.70E	Tell (O.C.			<u>-</u>			opsy formed? 2010	death?	-4	
	BeC	25. Was case refer	red to medical					26. Place of Dea			,	<del>- 70</del> 110	
hysic this ce al direc	ToE	examiner?	iNo	Hospital: 1 npatie	ent 2 🗆 E	R/Outpatient 3	DOA O	her: 4 🗆 Nursing H	Home 5 Res	sidence	6 Other (Spe	əcify)	
ing Ph Atter th uneral	on:	27. Manner of Deat 1 Natural	h 5 🗌 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	how inju	iry occurred		
tend Jeath tor: /	cati	2 Accident 3 Suicide	investigation 6  Could not be					Yes 2 No	096   casting	/C+++++	- d M	ural Route Number.	_
To the Hospital or Attending Physicien: within 24 hours alter death within 24 hoursel Director: Attent this certific completely tilled in by the funeral director.	Certification;	4 Homicide	determined	28e. Place of Inj building, et	c. (Specify)	ne, rarm, street,	ractory, office			own, State		urai Houte Number.	
spita nours nerel		29a. Certifier	f₩ Certifying Phy	ysician: To the best	of my know	vledge, death occ	curred at the ti	me, date and place	e, and due to the	e cause(s	) and manner a	s stated.	
ne Ho n 24 t he Fu oletely	edical	(Check only one)	2 Medical Exam	iner: On the basis o and manner st	f examinati ated.	on and/or investi	gation, in my	opinion, death occu	urred at the time	, date an	d place, and du	e to the cause(s)	
To the To the Comp	Σ	29b. Signature and	title of certifier	110			29c. Licens			29d. Da	ite signed (Mon	th, Dey, Year)	
		1 / ko	101	1/4	MD		RES	-000		Huzu	st 25,	2005	
6		30. Name and addr	A 55 1	impleted cause of c	leath (Item								
.5		Andrew 31. Date filed (Mon	-	SUN, MU	ar's Signati	Dina,	Flosp.	tol of E	saltimo	12			
Sta Registr		2.030 [01]	AUG 3 0	2005	Eus.	M. Kalo							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RAYMOND A. JACKSON State of Maryland / Department of Health and Mental Hygiene 0 0 5 tase Unpend Item 23a,pt.II,27,28a-f per me 6846 8-31-05 tas Reg. No. 28291 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $25^{\text{Day}}, 2005^{\text{Y}}$ **Physician** 0705 A M Raymond A. Jackson AUG. /Medical 4a. Facility Name (If not institution, give street and number) 1305 BEATTY AVENUE 4b. City, Town, or Location of Death ROSEDALE 4c. County of Death BALTIMORE Examiner If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAY 13, 1963 Birthplace (State or Foreign Country) **Funeral** 214-84-2965 42 Yrs Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ul Hygiene. other then "natural", or tems 23a or 28a-f ehov vent, the Madical Examirat cust be notified at 1X Yes 2 □ No Director Maryland **Baltimore** Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1305 Beatty Avenue 21237 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygle, important: if item 27 is marked other ti any injury or other traumatic event. The once. Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Allen Jackson, Jr. ဥ Mary C. Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Ann Rossi/wife 1305 Beatty Avenue Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/27/05 Baltimore, MD 21. Signature of Funeral Service Licensee Cremation Society of Maryland, Inc. McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Methadone intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dire to (or as a nonsequence of) Examine ettending physician and for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cocaine use 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Xees 2 No autopsy performed? certificete 12 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE ၉ this Alter thi 28a. Date of Injury 8-25-05 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: unk 6:45 found 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 No 2 Accident found a 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1305 Beatty Ave. Baltimore, Maryland 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide found at home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) AUG. 25, 2005 29b. Signature and title of certifie 29c. License number O.C.M.E 1000 who completed dause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201

Registrar DHMH 17 Rev 1/2001

State

m. 10

AUG 3 0 2005

32. Registrar's Signature

Tasha Zanee where

31. Date filed (Month, Day, Year)

		1	For State Registrar	State of Ma	-	epartment of I	Health and Me Death	ental Hygie	2000	28292
3	Physicia		1. Decedent's Name (First, Middle, Last	11-	, 7	- 000			Day Year	3. Time of Death
	/Medic	_	4a. Facility Name (If not institution, give	street and number)	L. J	4b. City, Town,	or Location of Death	ugust 1	9 2005 4c. County of Death	0010
		8	Saint Agnes	Hospi	tal		timure		10/4	
	Funeral Director		013 " Llo " lodlo"	M 2DF	7.5 last birti	Months Days	Hours Min.	Date of Birth Month Day, Ye	1930 9. Birth Con	place (State or Foreign untry)
	anyland •how		Usual Residence of Decedent  10a. State 10b. County	10	10c. City, Town	or Location	,			10d. Inside City Limits
	r 28e-f	rect	10e. Street and Number	//1	DHY	10f. Zip Code	-	10g.	Citizen of What Cor	untry?
	ath with	ra D	820 S. CAT	TOD AV	E.	2	1229		0.5.	A.
36		by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give		13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spectoan, Maxican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify:	
00-	2 hours		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edi		16a.	Decedent's Usual Occu	pation	168	o. Kind of Business/I	HI/E ndustry
21215		Completed	(Specify only highest grad	College (1-4or 5-	+)	life. DO NOT use retire	a during most of working ad)		STORE	
Maryland 21215-0036	be file ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Last)  EDGAR T.	TONES			18. Mother's Name (	First, Middle, Mail	den Sumame) MEKR	KEN
Aary	2 sh and ie m		19a. Informant's Name/Relationship (T	ype, Print)	19b.	Maifing Address (Stree	t and Number or Rural	Route Number, C.	ity or Town, State, Z	BATO. MD
	Health Health tem 27 other tr		20a. Method of Disposition	ROWN		GOO XH A Disposition (Name of	DOW Cla	te 200	Location - City or 1	Town, State
altimore,	00		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		BAV	r, crematory or other pla	ZM ACCE.	12 E	ALTO.)	MD.
Balti	permit. Pag Depertment Importent: I any Injury o		21. Signature of Strength eral Service Arens	Akres	2)	22. Nam, and Addr	ess of Facility	2940	DEON	STIZZY
i, la			23a. Part 1. Enter the diseas (, or comp shock, or heart failure. ) st only of				ing, such as cardiac or	respiratory arread	,	Approximate Interval Between Onset and Death
	Physician / /Medical	ì	Immediate Cause (Final disease or condition resulting in death)	4	SPIRAGI Consequence		MONIA			26 DAYS
	Examiner		Conventially list conditions		ON GES	11	ART FAIL	LURE		3 YEARS
V	ed isi	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	.,.	EEP API	1/2/		10 YEARS
, Č	be executed sicien and burial-transit	Exam	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequence		CC( /)(1	CH		(6)113
68760	2 2 2	dicai	(	d						
7 ×	Attending Physicien: The law requires that the death certifica or death.  •ctor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the certification of the contract of the certification of	Physician/Med	23b. was decedent pregnant	23c. If yes, outcome of		3 □Ectopic pregnanc	cv		23d. Date of delir	*
e +	the deal y the att	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Onknown		5 Other (specify)			Month	Day Year
1 R. P.	res that igned b be deta	ρχ	Part II. Other significant conditions co HYPERTEN		it not resulting in	the underlying cause g	iven in Part I.	23e. Did tobac	co use contribute to	
Argal	w require been si should t	leted	MULTIPLE		1 AC	OUIREN H	JEECTHA)	24a. Was an		opsy findings available
الم Re	The law	Completed	miget if ee	1102/11/1		WALLYED (	or cerroro	autopsy performed 1 Yes 2	prior to o death?	ompletion of cause of
Vital	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_   0	26. Place of Death (	Check only one		
es,	g Phys er this ieral di	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	nt 2 ER/Out	me of 28c. Inju	ther: 4 Nursing Home ury at 28	e 5 ☐ Residence id. Describe how i		ıfy)
Jone	ttending F death. ctor: After y the funera	catlo	1			M 10	Yes 2 □No			
Divi	ei or Attences after death	Certification:	4 Homicide determined	28e. Place of Inju building, etc	iry - At home, fai :. (Specify)	m, street, factory, office	28	it. Location (Stree City or Town, S	t and Number or Ru itate)	ral Route Number,
	To the Hospitel or Attu- within 24 hours after de To the Funerel Directo completely filled in by the	Medical (	29a. Certifier (Check only one)	vsician: To the best of iner: On the basis of and manner sta	examination and	death occurred at the t Vor investigation, in my	time, date and place, an opinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	Valinity To th comp	ž	29b. Signature and title of certifier	MENILL	IC DO	- 0	nse number		Date signed (Month	
	1	-	30. Name and address of person who d	completed cause of de	eath (Item 23a) (	Type, Print)	(7514		46 19	
	/		TAR 8 MA	4 11100	471	14B 6A	HTEWAY "	TERRA	CE MAI	RY UND RE 21227
	Sta Registra		31. Date filed (Month, Day, Year)  AUG 3 0	32. Regištra 2005	as Signature	Breeke		€;	OM L ( / /Y) b	TE 2122/
-	MALL 47 Day 4/00	0.4	11000	1						

DHMH 17 Rev 1/2001

		ľ	For State Registrar	State of Maryland /		it of Health and ie of Death	Mental Hygie Reg.	Z11115	28293
ľ	Physicia	n.	Decedent's Name (First, Middle, L.	ist)			2. Date of Death	Day Year	3. Time of Death
14	/Medic		HATTIE		1 01	ONES	August	28 2005	4:44 AM
	Examin	er	4a. Facility Name (If not institution, gr	ve street and number)	- 46. City	Town, or Location of Deat	041	4c. County of Death	
5	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last	birthday) If Under	1 Year If Under 24 Hrs Days Hours Min.		9. Birthp	place (State or Foreign
1	Director	2	26-64-0922	10M 2XF 69	Yrs.	Day's Hours Will.	7-77-	36 Nor	th Caplina
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			1	0d. Inside City Limits
	e Mar	ctor	MD	Ba	1+im	ore			1 As 2 No
	with th	Dire	10e. Street and Number	D: - 01 A.	10f. Zi	Code	10g.	Citizen of What Cour	ntry?
	ns 234	Funeral Director	1400 E. Mac	12. Was Decedent Ever in U.S.	13. Was Dece	dent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Americ	can Indian,
9	after or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	If Yes, spe	cify Cuban, Mexican, Puer 2 No Specify:	to Rican, etc.)	Black, White,	etc.
21215-0036	72 hours after death with the Maryland netural', or Items 23s or 28e-f show iteal Examiner must be rediffed at	ed by	3 Widowed 4 Divorced  15. Decedent's I	Year or Dates:	6a. Decedent's Usu		156	D	1ago
7	within 72 ene. than "ne	plet	(Specify only highest g		(Give kind of wi life. DO NOT L	ork done during most of wo	rking	. Kind of Business/In	dustry
	ed with ygiene tar tha	Completed	941		Mail	Sorter		MMUNI	cation
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "netural; or items 23s or 28e-f show any injury or other traumatic event, the Medical Examiner must be rolliked at once.	Be	17. Father's Name (First, Middle, Las	0 - 11		18. Mother's Na	me (First, Middle, Maid	den Sumame)	
Z Z	should nd Me mark mark	ပ္	19a. Informant Name/Relationship	(Type, Print) 1	9b. Mailing Addres	S (Street and Number or R	ural Route Number, Cit	ty or Town, State, Zip	Code) 2122 (
_	and 2 alth al		Della M. Tol	es (Doughter)	9901B	rliner Pla	ce. Ast. 7		River, MD
<b>Baltimore</b> ,	jes 1 (		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3	Removal from State 20b. Place ceme	of Disposition (Na etery, crematory or	me of other place)	Date 20c	. Location - City or To	own, State
Ħ	t. Pag rtment rtant:		`4 Donation 5 □ Other (Spec	ity) M+. L	ion Cer	retery 9-	2-05 1	altique	re, MD
Bal	Depar Depar Impoi any ir		21. Signature of Funeral Service Lice	nsee .	Varia	S LIONE	ene ten	Saltinuc veral Se to MD 2	risas 1212
П	¥ 5 4:		shock, or heart failure. List ont	nplications that caused the death. Dy one cause on each line.	o not enter the mo	de of dying such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Sepsis					3 days
В	Examiner		1	Due to (or as a consequence	ce of):				4 days
7	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	ce of):				- ady 5
V	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	an of):				
68760,	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	alE	l	Due to (or as a consequent	De Oi).				
_		ledical		U					
Box	uth cer tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	ath 3□Ectopic.p	regnancy		23d. Date of delive	ery Day Year
P.O. E	he dea the at	by Physiclan/M	1 Yes 2 No 9 Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (s	pecify)		Nonth	Day Teal
	s that t	y Ph	Part II. Other significant conditions	contributing to death but not resulting	g in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
Vital Records,	w requires been sign should be						1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
ecc	e law requ has been je 2 shoul	Completed					24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
<u>ه</u>	: The						performed 1 ☐ Yes 2 🗷	? death?	2/2(No
ĬĬ.	sician: Th certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒Ño	Hospital: 1 inpatient 2 ER/	Outpatient 3 D	Cthor	ath <i>(Check only one)</i> Home 5 🗆 Residence	S COther (Second	
of	g Physier this	n: To	27. Manner of Death			28c. Injury at Work?	28d. Describe how in		//
Sior	endin sath. or: Aft he fur	atio	1 Natural 5 Pending 2 Accident investigati	on	М	1 Yes 2 No			
Division	or Att	Certification:	3 Suicide 6 Could not 4 Homicide determine		, farm, street, factor	y, office	28f. Location (Street City or Town, St	and Number or Rura ate)	I Route Number,
	To the Hospitel or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying F	hysician: To the best of my knowled	dge, death occurred	at the time, date and place	a, and due to the cause	e(s) and manner as s	ated.
	the Ho lin 24 I the Fu opletel	ledical	one)	miner: On the basis of examination and manner stated.					
	To To	Σ	29b. Signature and title of certifier	- 44 0		c. License number		Date signed (Month,	
	,		30 Name and address of name of	O completed cause of death (Item 23a	a) (Type Print)	KES-000	140	gust 28	\$ 2005
	2				O Now	RES-OCC OFFE Str	eet BAIT	IMORE A	10 21287
	Sta		31. Date filed (Month, Day, Year)	EGOUDA 600 1 2005 32. Refistrar's Signature	19 Speak				
	Registr	ar	MUUU	,	6				

Norman Kistner Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-5725 State of Maryland / Department of Health and Mental Hygien 2005 AKG

28294

			Registrar			erinicate or	Dealii		Reg. No.		
E	Physici	an	1. Decedent's Name (First, Middle, Last)	_				2. Date of D	eath : 24 <sup>ay</sup> 200	ો <del>દ</del> ear	3. Time of Death 5:19 P M
	/Medic	al	Norman C. Kistr			45 Cit. T					J.17 1 M
	Examin	er	4a. Facility Name (If not institution, give s 6420 O'Donnell Str	eet			imore		4c. County	or Death	
	Funeral Director		213-40-0230	7. Ag	e (In yrs. last birthda 58 Yrs.	Months Days	If Under 2	Min. B. Date of Bi (Month, D)  Dec 3	, 1946	Coun	ace (State or Foreign try) Land
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location				10	Od. Inside City Limits
	be filed within 72 hours after death with the Maryland stal Hygiene. nd other then "naturel", or flems 23a or 28a-f show event, the Medical Examers must be notified at	Funeral Director	Maryland N/A			ltimore					1 No 2 □ No
	with th	Dire	10e. Street and Number			10f. Zip Code 2122	2/		10g. Citizen of		try?
	eath ne 234	erai	6420 O'Donnell Str	12. Was Decedent	Ever in ILS 1			in? (Specify Yes or N	US 01 14 Bac	e - America	an Indian
10	r iten		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐				in? (Specify Yes or N Puerto Rican, etc.)		ck, White, e	etc.
ğ	ours a	٤	3 ☐ Widowed 4 💆 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specity:		Specif	v: Whi	.te
5-0	72 ho	etec	15. Decedent's Educ (Specify only highest grade		(G	cedent's Usual Occu ve kind of work done	during most	of working	16b. Kind of B	usiness/Ind	lustry
Maryland 21215-0036	d within giene. or then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life	Driver	(d)		Tr	anspo	rtation
밀	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)					s Name (First, Middle		пө)	
yla	should be ind Mental s marked o umatic eve	Jo	Norman C. Kistner				1	eneva J. S	_		
	es 1 and 2 should to the literature of Health and Ment fitem 27 is market rother traumatics		19a. Informant's Name/Relationship (Ty) Diane Smith, Sibli	•				or Rural Route Numb parrows Po:			
Baltimore,	of He of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ R	emoval from State	20b. Place of Dis cemetery, o	position (Name of rematory or other pla	ce)	Date	20c. Location -		
ţ	. Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify)		Metro C	rematory :	Inc.	08/29/05	Baltimo		
Bal	permit. Pages. Department of It important: If ite eny injury or of once.		21. Signature of Funeral Service License Thomas Gregor	90		22. Name and Addr Cremation 299 Freder	Societ Societ ick Ro	y Of Mary ad Baltim	land Inc ore, Mar	vland	21228
			23a. Pert1. Enter the disease, or compli- shock, or heert failure. List only on	cations that caused se cause on each li	a the death. Do not	enter the mode of dy	ng, such as c	ardiac or respiratory a	arrest,		Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Merosch	eustic' ca	durasa	br di	sease			Onset and Death
	/Medical Examiner		rosulting in distant	Due to (or as	a consequence of);						
	3	er	if any, leading to immediate	Dua to (or as	a consequence of).						
7	outed Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
	th certificate be executed ending physicien and r use as the burial-transit	Exe	resulting in death) Last		a consequence of):						
ox 68760,	cate b physic the b	dica									
9 X	certifii ding p	n/Medicai	IF FEMALE:	3c. If yes, outcome	of pregnancy				22d Da	te of deliver	24
0			in the past 12 months?		2 Fetal death	B Ectopic pregnand D Other (specify)	у				Day Year
P.0	that the sed by the detach	Physicia	9 Unknown								
	8 50	by	Part II. Other significant conditions con	Luone	aleshir		ven in Parti.	\ \	,		e cause of death?
ő	w require been si should b	etec	- roprysena, c	- Voice		· 37k		24a. Was			
Records,	The lar ate has page 2	Completed						auto	psy ormed?	prior to con death?	sy findings available apletion of cause of
tal		a	25. Was case referred to medical				26. Place o	of Death (Check only		X RS	2 □ No
<u>=</u>	Physician: r this certific ral director,	To B	examiner? 1. <b>∑X</b> es 2 ☐ No	ospital:	ent 2 ER/Outpat	ient 3□ DOA Ot		sing Home 5□Res		er (Specify	at scene
n 0	g e		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injur	of 28c. Inju			how injury occur		
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□N				
Division of Vital	al or Al	Certification;	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, factory, office			(Street and Numb wn, State)	er or Hurai	Houte Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical C	29a. Certifier 1 Certifying Phys (Check only one) 2XMedical Examin	sician: To the best ner: On the basis o and manner st	f examination and/or	ath occurred at the tinvestigation, in my	me, date and opinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signe	d (Month, L	Day, Year)
)			Jan M 2	geet	nes	0	.C.M.E		Augus	st 25,	2005
	1		30. Name and address of person who co	mpleted cause of	leath (Item 23a) (Typ	e, Print) Penn	Stree	t, Baltimo	re, Mary	land	21201
			bisha Z Green	hero 1	1. Pi						
	Sta	ite	<ol> <li>Date filed (Month, Day, Year)</li> </ol>	JZ. Pugisti	ar's Signature	rd.					

State Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28295 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 29 Hu qust Year **Physician** 5:00 A M 2005 Eileen Catherine Kilmartin /Medical 4a. Facility Name (If not institution, give, speet and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HADRE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 05/08/1926 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2 💢 F Maryland 219-16-6222 79 Yrs **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any nighty or other traumatic event, the Marcial Exemples market intilities and once. 1 ☐ Yes 2 No Funeral Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5519 Channing Road 21229 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Martin Duffy Margaret Teresa McDonnell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William P. Kilmartin - Son 620 St. Johnsbury Road Baltimore, Maryland 21228 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Garrison Forest
Veterans Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/06/2005 Baltimore, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 8 day Immediate Cause (Final Urosepis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to minimal cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) YELLYS Physician/Medical use as i ed by the attending detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2[] No 2 3 No 1 Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 1 Tes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification the Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D0062070 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Ave Caton 32. Registar's Signature 31. Date filed (Month, Day, Year) State Registrar

Amend item#8, per AB, (301,1724/06 II Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 23, 2005 4:40 A M Earline Joyce Kelly /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 2/25/1996. Birthplace (State or Foreign (Month, Day, Year) **Funeral** 1 ☐ M 2 🕏 F Director 69 218-32-3682 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits rel', or Items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2510 Harwood Road 21234 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married "naturel", or 1 ☐ Yes 2 ☑ No ģ Specify: white 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. 12 independent contractor Balto Co Parks & Rec f Health and Mental Hygid Item 27 is markad other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 is marked otherny injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl Stevens Ruth McCarty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura C. Steele/daughter 2510 Harwood Road Baltimore, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 \ Donation 5 □ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Faci Ronald So Wade State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Part 1. A ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or year failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC LUNG CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 Yes 2 No 1 Yes 2 1 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director; 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medice! Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7621

Harris Land

3. Registrar's Signature

BOON P. LIM M.D.

31. Date filed (Month, Day, Year) AUG 3 0 2005 D 37254

OSLER DRIVE TOWSON MARYLAND 21204

2

05

State of Maryland / Department of Health and Mental Hygiene, 28297 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 2005 11:00 amm VIRGINIA LEE LEDERMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo July 28, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min 1□M 2□F Yrs. 1937 China 266-50-4485 68 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or Iteme 23a or 28a-f ehow treumatic event, Its Madical Exemplant mast be notified at 1 ☐ Yes 2 ☐ No Director MD Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12520 Blue Pond Terrace 20705 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXXo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2000 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2XXVo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Doctor's Office Grade 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mildred Moffitt Leland T. Tinsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12520 Blue Pond Terrace Beltsville, MD 20705 Arnold Lederman spouse 20a. Method of Disposition
1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H
Importent: If Ite
any injury or ot 8/26/2005 West Arundel Crematory Odenton, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonaldson Funeral Home, P.A. 45× 400 M00770 Laurel, Maryland 20707 313 Talbott Avenue Approximate Interval Between Onset and Death 5 MONTHS 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Breast Cancer /Medical Due to (or as a consequence of) **Examiner** 1 week Post - obstructive pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien 68760 requires that the death certificate be Physician/Medical use as the l Box ( IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 4□Pregnant at time of death P.O. the 8 detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à eq Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 🔏 0 Hyperlipidemia 24a. Was an certificate has autopsy 2**XX**Io 1 ☐ Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2XXVo After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XX atural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funerel D \*\*Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tle of certifier かってていいいい D0057216 ANG 22,2005 中からいにいなん 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 VAN DUSEN NO, LAUREZ MO 26707 Low ph 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2005 ENLINE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28298 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2005 **Physician** Doris Α. Loewer August 8:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare-Perring Parkway Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, )
Jan. 29, Birthplace (State or Foreign Country) **Funeral** Days Year 1 ☐ M 2 🕱 F 89 219-26-1961 Yrs. 1916 **Director** Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Baltimore. Director Maryland Baltimore. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4200 Garland Avenue 21236 natural', or items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 ☐ Widowed 4 💆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be lifed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatic event, If a Madis once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Psychiatric Hospital 12th Grade Psychiatric Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alexander Dooley Maru Leftwich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Paul J. Loewer (son) 4200 Garland Avenue, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 8/30/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Juneral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Separatelly list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760, ned by the attending physician detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No 24a. Was an certificate has autopsy ☐ Y85 - 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA 1 Irrsing Home 5 Residence 6 Other (Specify) this 27. Manne of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: 1 atural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 □ Could not be 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2005 ▶

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician AUGUST** LEVIN 2005 THEODORE 9:17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RICHEY HOSPICE BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 01/05/1921 Birthptece (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 100 M 2□ F Director MD 219-05-5797 84 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Michigal Examinar must be notified at BALTIMORE BALTIMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3620 BELLMORE ROAD 21244 U.S.A. Completed by Funeral Was Decedent Ever in U.S. Armed Forces?
 1 \( \) Yes 2 \( \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 Yes 2 No If Yes, Give Year or Dates: WWII Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hyglene.
Importent: If Item 27 is marked other than "na any injury or other traumatic avent the "name once." College (1-4or 5+) Elementary/Secondary (0-12) MACHINIST MARYLAND CUP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JOSEPH** LEVIN LILLIAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ETHEL B. LEVIN / WIFE 3620 BELLMORE ROAD - BALTIMORE, MD 21244 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CONG. 08/29/2005 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License SCO 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** Years /Medical Due to (br as a consequence of): **Examiner** Caronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nsequence of Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No this certificate has autopsy performed 1 Yes 2 12 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richey Hospice N. Entaw St. Baltimore, MD 21201 E. TSO MD 31. Date filed (Month, Day, Year) State AUG 3 0 2005 Registrar

DHMH 17 Rev 1/2001

EVIN

neadare

State of Maryland / Department of Health and Mental Hygiens 28300 Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) August 26, 2005 6:24PM **Physician** Miller Norma /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Howard County General if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Ste Country)

August 15,1911 Indiana Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F 220-36-9606 94 Yrs. Director Usuel Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Haatth and Mental Hygiena. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat must be notified at 1 XYes 2 No Funeral Director Maryland Howard Columbia 6 4 1 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours after death with Hygiena. Hygiena. 7110 Minstrel Way Apt. 233 21045 United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) 5+ Elementery/Secondary (0-12) Teacher Public Schools 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Berton Small Alma Mae Purdue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marvin R. Miller, Son 4924 Carteret Drive, Raleigh, North Carolina27612 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maple Grove Cemetery Sept.1,2005 Boonville, Indiana 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Koehler Funeral Home of Funeral Service Licen MO1113 304 East Main Street, Boonville, IN 47601 so, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Per 1. Enter the disees shock, or heart tailure **Physician** 23 Immediate Ceuse (Final disease or condition resulting in death) /Medical Sepsis Examiner Due to (or as a consequence of) Physician/Medical Examiner signed by the attanding physicien end d be detached for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2540 1 ☐ Yes 2 ☑ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this s eftar deeth. ii Director: After this ed in by tha funerel d 28c. 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury at Work? 1. Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funeral C completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier 29c. License number 1 notem st 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Little Pat xent Plany Colombia MO 21044 4205 11053 Cong Braum. KMD 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

Registrar **DHMH 16 Rev 6/95** 

State

₹		1 - For State Registrar	State of Maryla			of Heal of Dea			giene Reg. No 20	05	28301
Physic	an	Decedent's Name (First, Middle, Last	)					2. Date of Dea Month	ith Day	Year	3. Time of Death
/Medi	cal	JESSIE  4a. Facility Name (If not institution, give	street and number)	MOR		own, or Loca	tion of Death	AUGUST	21	2005 by of Death	11:35 A <sup>M</sup>
Examin	ner	Gladys Spellman	·		,	verly	tion of Death	1			eorge's
Funeral	П	5. Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday)	If Under 1	Year If U	nder 24 Hrs.	8. Date of Birti (Month, Day		9. Birtho	lace (State or Foreign
Director		169-34-661/	<sup>™ 2</sup> √F 85	Yrs.	Months	Days Ho	ours Min.	August	15 192	20 U/	
and		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation					1	Od. Inside City Limits
Many 18hc	to	MD Prince ge	orgale	Cheve	rlv						ty⊡Yes 2 □ No
r 286	Director	10e. Street and Number	orge s	Offeve	10f. Zip (	Code			10g. Citizen of	What Cour	itry?
th wit	ai D	2900 Mercy Lai	ne			2078	35		U.S.A	١.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28e-1 show any highry or other traumatic event, the Medical Exemplant must be notified at once.	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede	ent of Hispani fy Cuban, Me	ic Origin? (S exican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ	
36 rs after	by F	1 ★Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		1□Yes 2	₩ No Spi	ecify:		Speci	fv·	
2 hou		15. Decedent's Edu	cation	16a. Dece	dent's Usual	Occupation			16b. Kind of I	Bla	
21215-0036  od within 72 hours af gjene. er than "natural; or the Medical Evern	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work DO NOT use	done during retired)	most of wor	king			,
21 ygien th	Соп	U/K		U	/K				U/K		
Maryland of 2 should be file lith and Mental Hy 17 is marked oth traumatic event	Be .	17. Father's Name (First, Middle, Last)						ne (First, Middle,	Maiden Suma	me)	
Maryland 2121. 12 should be filed within is and Mental Hygiene. T is marked other then ", traumatic event, tra Mes	T <sub>0</sub>	U/K 19a. Informant's Name/Relationship (T)	one (Print)	105 11-15		U/1					
Man than traum	1 3	Robert Eiring/ Re						rai Route Numbe rly, Mar	-		Code)
Baltimore, Mi permit. Pages 1 and 2 Department of Health is Important: if Itam 27 is any injury or other tra once.		20a. Method of Disposition		Place of Dispo	sition (Name	e of	Office	Date Tide	20c. Location		wn, State
altimore, mit. Pages 1 ar partment of Hea portant: if Itam y injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Dther (Specify)		cemetery, crer	-		i	, T	) free and a	lo Mo	ww.land
mit.		21. Signatur of Type 15. viv. Licens	1 11	iverdal				B. Jenl	Riverda Kins Fu	neral	Home
Depa Depa Impo	6 0							l Landove			
		23a. Part1. Enter the disease, or complishock, or heart tailure. List only o	ications that caused the dea	ath. Do not ent	er the mode	of dying, suc	h as cardiac	or respiratory are	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	ARTERIOSCLE	ROSTIC	HEART	DISEAS	SE				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse PEREPHERAL		D DTC	FACE					
	-	Sequentially list conditions,	Due to (or as a conse		W DIS	EASE					
uted 3 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ENCEPHALOPA		SPIRAT	ORY FA	LLURE				
exector and and and and and and and and and and	Еха	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					<del></del>	-	
58 / 60, cate be executed physicien and sthe burial-transit	dicai		d								
	Med	IF FEMALE:									
. BOX 6 death certific death certific for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pre	gnancy				ate of delive	ry Day Year
. 0 00	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5□	Other (spe	cify)				oriu)	Day real
I KECOIGS, P.O. The law requires that the tite has been signed by the bage 2 should be detache.	/ Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying car	use given in F	Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?
COLDS, P. w. requires that is been signed to should be det	d by							1 🗆 Y	s 2□No	3 Prob	abiy 4 X Unknown
Hecords, he law requires t e has been signe age 2 should be o	olete							24a. Was a	n 24b.	Were autor	esy findings available
The la	Completed				-			autops	ned? 2 <b>2</b> No	death?	osy findings available apletion of cause of
	Be C	25. Was case referred to medical examiner?				26. F	Place of Dea	th (Check only or		1 1 1 1 1 1 1 1 1 1 1	2X No
- X	일	1 ☐ Yes 2 No	lospital: 1 Inpatient 2	∃ER/Outpatien	t 3 DOA	Other: 4	X Nursing H	ome 5 Reside	ence 6 🗆 Ott	ner (Specify	)
DIVISION OT ior Attending Physical death. Director: After this lin by the funeral di	iuo.	27. Manner of Death 1   Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury at Work?		28d. Describe h	w injury occur	red	
Attending ar death.	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Plans of Injury At h		M	1 Tes	2 □ No	201 1 (0			
DIVISION ATTENDATE DISCOLUTION DE THE	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At Inbuilding, etc. (Special	ify)	eet, factory,	office		28f. Location (Si City or Town	reet and Numi n, State)	oer or Hurai	Houte Number,
DIVISION O To the Hospitel or Attending PP within 24 hours after death. To the Funarel Director: After th completely illied in by the funeral		29a. Certifier 1 X Certifying Physics	sician: To the best of my kn	owledge, death	occurred at	the time, dat	te and place.	and due to the c	ause(s) and m	anner as st	ated
n 24 h	edical	(Check only 2 Medical Exami one)	ner: On the basis of examin and manner stated.	ation and/or inv	estigation, i	n my opinion,	death occur	red at the time, d	ate and place,	and due to	the cause(s)
To the within 2 To the complet	Ň	29b. Signature and title of certifier	de .		29c.	License num	ber	2	9d. Date signe	d (Month, L	Day, Year)
^		I hull	MA		D	002602	.9		August	23	2005
, >		30. N e and address of on who co	mpleted cause of death (Ite	m 23a) (Type,	Print)		т. •				
	10	Lester Miles M 31. Date filed (Month, Day, Year)					Landov	er, Mary	/Land 2	0/85	
Sta Registr	3.0	AUS 3 0 2	407	15 1	mesi)						

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar 28302 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Cecelia Spear McCrav 26 9:35 AM AUG 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ST. AGNES HEALTH CARE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 89 Yrs. 213-38-1900 Director November 25, 1915 Montana Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d Inside City Limits 10a State "natural", or Items 23a or 28e-f show Maryland Baltimore Catonsville 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed other then "natur vent, I've Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Research Laboratory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental Is marked William Delmont Spear Mattie Morgeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6436 Spicewind Court, Columbia, MD 21045 Thomas G. McCray/ Son Important: If Item 27 Baltimore, 20b. Place of Disposition (Name of Geo." Wash. Unit Versity August Medical Center 2005 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of 4X Donation 5 ☐ Other (Specify) Washington, D.C. Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL ACUTE INFARCTION disease or condition resulting in death) HOURS /Medical Due to (or as a consequence of): Examiner DISEASE COROMARY ARTERY MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner nding physician and use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) detached the 9 Unknown o 9 Unknown Š نے cate has been signed to page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, STENOSTE 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 1 No Vital Be 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 2 ER/Outpatient 3 DOA ŏ this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Dire 9 1 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. P 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P19510 Masms DOCTOR AUG, 26, 2005 30. Name and diress of person who completed cause of death (Item 23a) (Type, Print) S A NES HEA - CARE, 900 S CARON VE BACIM YA MIN - ALI JAMIRANT 31. Date filed (Month, Day, Year) AUG 3 32. Registar's Signature State Registrar

DHMH 17 Rev 1/2001

W

W

U

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28303 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 2:40A 2005 0 4c. County of Death 4b. City, Town, or Location of Death 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day 1 M 2 □ F Months Days Hours Yrs. 10b. County 10c. City, Town or Location 10f. Zip Code 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Black, White, etc. 1 Yes 2 No Specify: If Yes, Give Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

**Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country.) Social Security Number **Funeral** 220 - 74 - 3636 Usual Residence of Decedent Director with the Maryland 10d. Inside City Limits 10a State show traumatic event, the Medical Examiner must be notified at 1 Xes 2 No Director 10e. Street and Number ŏ Items 23a Funeral 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò Completed by 3 Widowed 4 Divorced "natural', 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within fealth and Mental Hygiene. om 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 433/5 19a. Informant's Name/Relationship (Type, permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician ardiothrombotic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregr 3 Ectopic pregnancy in the past 12 mor Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 🗌 No 3 🗌 Probably Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Tyes 2 1 Impatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: To the Hospital or Attending 1 Natural Injury 1 Tes investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Do0 57465 of person who completed cause of death (Item 23a) (Type, Print) 25 Main st. ) suite 200, Repsterstown, MD. 21/36 N.S. KajapakseND

Registrar DHMH 17 Rev 1/2001

State

1 - For State Registrar

32. Registrares Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 28304 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Dennis Tiee Majors August 2005 1605 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year)

November 30, 1947 Birthplace (State or Foreign Country)
 MD. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□F 216-503080 57 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If Item 27 is marked other then "natural", or items 23s or 28s-f ehow 10a. State 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-1 ehov other treumatic avent, the Musical Exactinar must be notified at 1 ☐ Yes 2 X No MD Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 East Baltimore Street 21224 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Association of Elementary/Secondary (0-12) College (1-4or 5+) Maryland Pilots Dispatcher 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Pilarski Earl Thomas Majors ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7101 East Baltimore Street, Baltimore, Md. 21224 Virginia Majors wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State September ŏ permit. Page Department of importent: If any injury or ange. Carrison Forest V.A. Cem. 4 Donation 5 Other (Specify) 6, 2005 Owings Mills, Md 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 21. Signature of Funeral Service Licensee, 23a. Part 1. Enter the disease or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Atherosclevotic Cardiovascular Diseas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien end for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been sign, , page 2 should be Wei 3 Probably 4 ☑ Unknown 1 Tyes 2 No Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 No within 24 hours after death.

To the Funeret Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME Mallan ma August, 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ME 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2005 0

State of Maryland / Department of Health and Mental Hygien 2005 28305 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** August 27 2005 Miklochik /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Rosedale Franklin Square Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1□M 2X F Months Hours 74 212-28-6832 MD Director December 16,1930 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or Itams 23a or 28a-f show traumatic evant, the Madical Exont out must be rigified at 1 Yes 2X No Completed by Funeral Director Baltimore Dundalk MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21222 7167 Holabird Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bailey Supply Bookkeeper 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Anna Swanson Ancle Stafford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7307 Martell Avenue, Dundalk,MD. 21222 Department of Health a Important: If item 27 is any injury or other tra once. daughter JoAnna Keller 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Carrison Forest VA Ceme. Owings Mills, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 7, 2005 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licensee 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a. Metastatic lung and Pharyngeal Cancer
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. E. its. Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. | 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred al or Attending P after death. I Diractor: After I Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - AI home, farm, streel, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral E 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 0 9000 Franklin Square Drive Ballimore Maryland DR Kelly L. Miller 32/Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2005 Registrar

Wiklochik,

			1 - For State Registrar	State of Maryland / Dep Ce	artment of Health and M rtificate of Death	lental Hygi	ene g. No. 2005	28308
	5		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Donna Jean N	Miller		August 2		5:10 a. <sup>M</sup>
4	Examir		4a. Facility Name (If not institution, give s. 7601 Gambier Dri		4b. City, Town, or Location of Death Upper Marlboro		4c. County of Death Prince Geo	orge's
	Funeral Director		5. Social Security Number 6. Sex 213 78 9030 1□	7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day June 2)	Year) Cour	place (State or Foreign htry) nington DC
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
	Mar	to	Maryland Prince (	George's Upper Ma	rlboro			1 ☐ Yes 2 No
	n 188	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?
	h wit	0	7601 Gambier 1	Drive	20772		United Stat	tes
36	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "naturel", or iteme 23e or 28e-f show event, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 21771No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2∏XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
2-00	72 hou	eted	15. Decedent's Educ (Specify only highest grade	ation 16a. Dece	dent's Usual Occupation a kind of work done during most of work	ing	6b. Kind of Business/In	dustry
21215-0036	filed within Hygiene. ither then "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)  ralegal		Law	,
land 2	should be filed within od Mental Hygiene. marked other than imatic event, the M	To Be C	17. Father's Name (First, Middle, Last) Orville M. Mille	er	18. Mother's Name Doris	(First, Middle, N Dillard	faiden Surname)	
Maryland	th at 27 is		19a. Informant's Name/Relationship (Type Doris Throckmorton		ng Address (Street and Number or Run 2 Newglen Ave, Dist			,
Baltimore,			20a. Mathod of Disposition  142 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other place) Aug 30, con National Cemete	2005	Oc. Location - City or To Suitland, Ma	
Balti	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service License	and moores?	2. Name and Address of FacilityLee	Funeral	Home,Inc 60	
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	ations that caused the death. Do not en e cause on each line,	ter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	hronic alcoholism			yes
A.	red	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
68760,	ficate be executed physicien and is the burial-transit	edicai Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):				
P.O. Box 68	ath certif stending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ary Day Year
	quires that the de n signed by the o	þ	Part II. Other significent conditions conf	nbuting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
of Vital Records,	The lew require	Completed				24a. Was an autopsy perform	prior to conded? death?	psy findings available impletion of cause of
tal		0	25. Was case referred to medical		26. Place of Deat			2 No
<u> </u>	Physicien: rthis certification and director, i	0.0	examiner? 1 X Yes 2 □ No	ospital:	0		nce 6 Other (Specif	v At scope
	ding Phy h. After thi funeral	ın: ⊤	27. Manner of Death 1 KNatural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe ho		Ht Scene
Division	eatl or:	icatio	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	28f Location /Str	eet and Number or Rura	I Pouto Numbos
Di∧	sal or Attendes selfer death	Certification:	4 Homicide determined	building, etc. (Specify)	real, lactory, office	City or Town		ir House Number,
	To the Hospital or Atten within 24 hours efter deat To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, deat er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, investigation, in my opinion, death occurrence.	and due to the ca red at the time, da	use(s) and manner as si te and place, and due to	tated. the cause(s)
	To the Comp	×	29b. Signature and title of certifier		29c. License number OCME	1	d. Date signed (Month,	
	/		30. Name and address of person who con	npleted cause of death (Item 23a) (Type	Print)		August 24, 2	
	2		30. Name and address of person who cor Pamela E. Souti		.11 Penn Street Ba	altimore,	, Maryland 2	21201
	Sta Regista		31. Date filed (Month, Day, Year) AUG 3 0 200	32. Hogstrar's Signature	radio .			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 9 0 5 28307 For State Registrar AMEND ITEM #9,15,17,18&19a&Berrit Cate (Beath /30/05 JH Reg. No. 2. Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) August 11, Day 2005 Year **Physician** 4:37р м William Mather /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | Mar 27, 1955 9. Birthplace (State or Foreign Country) WASH D 5. Social Security Number 6. Sex 11∆ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** WASH DC Yrs. 50 Director unk Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County 27 is marked other than "natural", or Itams 23e or 28e-f show traumatic evant. The Madical Exametractimatic Exciting at 1 ☐ Yes 2 ☐ No Director Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 534 20794 permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23e any injury or other traumatic event unk Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 Tyes 2K No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) unk unk unk <del>unk</del> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be NANCY JUNE ALLEN 2 PAUL LUKER MATHER, JR. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code WESTERN STAR RUN CLARKSVILLE, MD. 21029 19a. Informant's Name/Relationship (Type, Print)
PAUL, MATHER/brother
Laurel Regional Hospital usen Rd. Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of uneral Service Licensee Ronal S. Wade novo 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 days Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown carcinoma lung Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Yes 2 ☐ No 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D24253 30. Name and address of person who, completed c ause of death (Item, 23a) (Type, Print) Laurel md 2010 una mme 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 Belle Jed Registrar

Baltimore, Maryland 21215-0036

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Items 23a or 28s-1 show any injury or other traumatic event, I'm Medical Exactlinational Centralination and ODGS.

Pnysician /Medical **Examiner** 

	68760, < iiiicate be executed ag physician and as the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Disseminated Intranscular Countries of the consequence of the consequence of the countries of the countri
	cords, P.O. Box 68760, wrequires that the death certificate be expeen signed by the attending physician should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnancy  1
	Division of Vital Records, P.O. Box 68760, <a href="https://doi.or.or./10.100/">or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.</a>	e Completed by I	hypertension Acute Rena	
ત્ર	Ysicia ysicia s cert	To B	examiner?	Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing
susar	Division of Vital Recont the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Work?  On Month, Day Year) 28b. Time of Work?  1 Yes 2 No
V)	or Att frer de Sirect in by t	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	Physicien: To the best of my knowledge, death occurred at the time, date and plac aminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.
	To th withir To th	M	29b. Signature and title of certifier	29c. License number

	1	For State of Maryla		irtment of tificate of		Mental Hygie Reg.		28308
cian lical		Decedent's Name (First, Middle, Last) Susan Victoria Moore				august	Day Year 27,2005	
iner I	5	219–56–5113 1□M ¾□F 56	rs. last birthday) Yrs.			8. Date of Birth (Month, Day, Ye	ar) Co	thplace (State or Fore buntry) cyland
or	1		City, Town or Lo	cation				10d. Inside City Lim
Director	1	0e. Street and Number	ssex	10f. Zip Code 2122			Citizen of What Co	ountry?
by Funeral	-	11.21 "B" Sandystone Road  1. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  1. Was Decedent Ever in Armed Forces?  1 Yes 2 No II Yes, Give Year or Dates:	f	Vas Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No-	S. A.  14. Race - Ame Black, Whith Specify:	
To Be Completed by Fi		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12) Colfege (1·4or 5+)  12	(Give	DO NOT use retii	e during most of world	king	wn Home	
o Be C		17. Father's Name (First, Middle, Last)  Henry Edward Wheeler	, azonar		18. Mother's Nam	ne (First, Middle, Mai Berry		
To		19a. Informant's Name/Relationship (Type, Print)  Heather Renshaw (Daughter)	1	g Address (Stree	et and Number or Ru	ral Route Number, Co Middle Riv		
clan/Medical Examiner		23a. art1. Enter the disease, or complications that caused the disease or product of the caused the disease or gondition resulting death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  23a. art1. Enter the disease, or complications that caused the disease or each line. Due to (or as a considerable of the complex of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a considerable of the cause of the	eath. Do not ent  Shootsequence of):  ive Enterted 3	docar	ki Funeral Eastern Av ying, such as cardiac	Home PA Zenue Ess. or respiratory arrest.		and 21221 Approximate Interval Between Onset and Death
Physician/M		IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑No 9 ☐ Unknown  23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etaf death 3 [	Ectopic pregnar Other (specify)			23d. Date of de Month	livery Day Year
þ	F	Part fl. Other significant conditions contributing to death but not	resulting in the u	nderlying cause (	given in Part I.		co use contribute t	o the cause of death robably 4 Monkho
Completed	1	Acute Renal Failure				24a. Was an autopsy performed	prior to death?	utopsy findings availa completion of cause
o Be (	1	25. Was case referred to medical examiner?  1  Yes 2 No  Hospitaf: 1 Inpatient	2 ☐ ER/Outpatier		Who are	th (Check only one)	- 0 DON (C	24.1
ertification: To	1	27. Manner of Death  1 Matural  2 Accident investigation  3 Suicide 6 Could not be determined  4 Homicide determined  28a. Date of Injury (Month, Day Year)  28a. Date of Injury - A building, etc. (Sp	28b. Time of Injury	28c. In W	ury at ork?	ome 5 ☐ Residence 28d. Describe how  28f. Location (Stree City or Town, S	injury occurred	
edical Cer	-	29a. Certifier  (Check only 2   Medical Examiner: On the basis of exam	knowledge, deatl	n occurred at the	time, date and place y opinion, death occu	, and due to the caus	e(s) and manner a	s stated. e to the cause(s)
Med		29b. Signature and title of certifier  Pring Grang m1		RE	nse number		Date signed (Mon	th, Day, Year) 27, 2005
		30. Name and address of person who completed cause of death (	Mars 02a) (T		T: - 13		_	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 11:59AM 28 Charlotte Elizabeth McDorman 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 200 Days Hours 91 9-19-1913 Director 226-10-7180 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, Its Modical Exactions for notified at 1 □Yes 2 XNo Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 310 6th Ave NE Completed by Funeral 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager - Cafeteria AA County School System 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Oliver R. Hess Willie A. Landis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 8235 Appalachian Drive, Pasadena, MD Audrey McDorman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 8-31-05 ' 4 □Donation 15 □ Other (Specify) Glen Haven Mem Park Glen Burnie, MD ce Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Ave SW, Glen Burnie, MD 21061 monso Part 1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death i m diate Cause (Final di ase or condition ACUTE Physician MYDEARDIAL INFARETION disase or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a prossiowing offs Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Physician/Medical А IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an RENAL page 2 s autopsy performed? 2 **U**NO 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 40 Mo 2 1 Tyes this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After to the Hospital or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \text{Homicide} \) 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai within 2 To the I and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUG 29, 2005 , ms 30. Name and address of period who completed cause of death (Item 23a) (Type, Print) 2601 VeTerans Nes Mwy niljersville ND 21108 Monit 31. Date filed (Month, Day, Ybar) 32. Registrar's Signatur State Registrar AUG 3 0 2005

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

19 17 bi -	an	Decedent's Name (First, Mide     ROSE	dle, Last)			MUROV	T T 7	2. Date of De AUGUST	_	y 2005 <sup>ar</sup>	3. Time of Death 12:45P
Medic xamin		4a. Facility Name (If not instituti	ion, give street and i	number)		4b. City, Town, or			4c.	. County of Death	)
		MONTGOMERY GE 5. Social Security Number	NERAL HOS	PITAL	la a t hirth day	OLNEY If Under 1 Year	If Under 24	Hrs.   0. Date of Bi		10NTGOME	
neral ector		211-14-5592	1 ☐ M 2 💢 F	7. Age (In yrs. 95	Yrs.	Months Days		Ain. 08/01/1	910°	9. Birth	place (State or Foreig intry) PA.
20		Usual Residence of Decedent 10a, State 10b, Coun	tv	10c Ci	ity, Town or Lo	ocation					10d. Inside City Limit
a notified at	ro	MD HOWA	<i>'</i>		COLUMB						1 ☐ Yes 2 X N
EDAM!	lrec	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou	untry?
distr	raiD	10030 MAPLE A				21046				U.S.A.	
or other traumatic event. It is Medical Exercitive must be multipled at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce	Arried Armed	ecedent Ever in U Forces? s 2 1 No Give r Dates:		Was Decedent of H If Yes, specify Cuba  1 Yes 2 No	ispanic Origin' in, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	)-	14. Race - Ameri Black, White Specify:	
dical	eted	15. Decede (Specify only high	ent's Education	ad)	16a. Dece	dent's Usual Occupi kind of work done of DO NOT use retired	ation during most of	working	16b. K	ind of Business/Ir	ndustry
N N	Completed	Elementary/Secondary (0-12)	College	e (1-4or 5+)	HOMEN		1)	•		OWN HOME	
ent.	Be Co	17. Father's Name (First, Middle	e, Last)		1101121	WINCH	18. Mother's	Name (First, Middle			
	To B	PAUL		S	CHWART	Z	ANN	IA.		UN	KNOWN
treum		19a. Informant's Name/Relation	DAUGHTER					- COLUMB			ip Code)
OTDE		20a. Method of Disposition		20b. I		osition (Name of matory or other place		Date		ocation - City or T	own, State
		1 ABurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other				MEMORIAL	08	/28/2005	COL	UMBIA, M	1D
any injury once.		21. Signature of Funeral Service	e densée	~				SOL LEVINS ROAD - F			
cian		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition	or complications that st only one cause of	n each line.	th. Do not en	ter the mode of dyin	g, such as car	diac or respiratory a	rrest,		Approximate Interval Between
		resulting in death)	_ a	PNEUMON	IIA						1 WEEK Death
		resulting in death)	Due Due	to (or as a consec	quence of):						
er	ner	resulting in death)	b		quence of):						1 MONTH
er	xaminer	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Entail Indomining Cause (Disease or injury that initiated events resulting in death) Last	b. Due	to (or as a consec DYSPHAG to (or as a consec	quence of): iIA quence of):						
ner	al Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	b. Due	to (or as a consec DYSPHAG	quence of): iIA quence of):						
ner Duriar-transit	Aedicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due	to (or as a consec DYSPHAG to (or as a consec	quence of): iIA quence of):						
or use as the burial-transit		resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	b	to (or as a consect DYSPHAG to (or as a consect to (or as a consect to (or as a consect to control	quence of): iIA quence of): quence of): quence of):	□Ectopic pregnancy □ Other ( <i>specify</i> )				23d. Date of deliv Month	1 MONTH
חפר מפומכוופת ומי מאם מא נוופ מתומי-וומואוי	by Physician/M	resulting in death)  Sequentially list conditions, if any, leading to immediate class. End Indominal Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	b. Due  c. Due  d. 23c. If yes, 1 Liv 4 Pre 9 Un  tions contributing to	to (or as a consect DYSPHAG to (or as a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a co	quence of):  i I A quence of):  quence of):  quence of):  ancy al death	Other (specify)	en in Part I.	23ə. Did t	obacco u	23d. Date of deliv Month	1 MONTH
page 2 should be detached for use as the burial-transit	by Physician/M	resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1  Yes 2  No 9  Unknown  Part II. Other significant condi	b. Due  c. Due  d. 23c. If yes, 1 Liv 4 Pre 9 Un  tions contributing to	to (or as a consect DYSPHAG to (or as a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a consect to (or a co	quence of):  i I A quence of):  quence of):  quence of):  ancy al death	Other (specify)	en in Part I.	24a. Was	obacco u Yes 2	23d. Date of delive Month  use contribute to the State of	1 MONTH  very Day Year  the cause of death? bably 4 □Unknown
page z strouto pe detacried for use as the burlandiante.	Be Completed by Physician/M	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Education of the leading to immediate cause. Education of the leading	b. Due c. Due d. 23c. If yes, 1 Liv 4 Pre 9 Un tions contributing to	to (or as a consect DYSPHAG to (or as a consect to (or as a consec	quence of):  iI A quence of):  quence of):  anancy al death 3E death 5E sulting in the u	Other (specify)	26. Place of	24a. Was autor perfo 1 Yes	obacco u Yes 2 an osy ormyd? 2 No	23d. Date of delive Month  Ise contribute to the second of	The cause of death?  bably 4 Unknown  popy findings available  and the cause of death?
Oliector, page z situato de detacried los as tile bullar tialisti	To Be Completed by Physician/M	resulting in death)  Sequentially list conditions, if any, leading to immediate course. Enter Index I	b. Due c. Due d.  23c. If yes, 1 Liv 4 Pre 9 Un tions contributing to LAR INSUF	to (or as a consect DYSPHAG to (or as a consect to (or as a consec	quence of):  A quence of):  quence of):  quence of):  anancy al death 3 [ death 5 [ sulting in the u	Other (specify)  nderlying cause give	26. Place of er: 4 🗆 Nursin	24a. Was autor perio 1 Yes	obacco u Yes 2 an posy primyd? 2 No	23d. Date of delive Month  Use contribute to the second se	The cause of death?  bably 4 Unknown  popy findings available  and the cause of death?
ner and the second of the seco	To Be Completed by Physician/M	resulting in death)  Sequentially list conditions, if any, leading to immediate course. Entail Industry, Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due  c. Due  d. 23c. If yes, 1 Liv 4 Pre 9 Un  tions contributing to LAR INSUF	to (or as a consect DYSPHAG to (or as a consect to (or as a consec	quence of):  iIA quence of):  quence of):  anancy al death 3E death 5E sulting in the u	nderlying cause give	26. Place of er: 4 🗆 Nursin	24a. Was autor performed in the control of the cont	obacco u Yes 2 an posy primyd? 2 No	23d. Date of delive Month  Use contribute to the second se	The cause of death?  bably 4 Unknown  popy findings available  and the cause of death?
חומרתן לשמפ ל פונסתום הם תפופתיום וכן תפם שם נוום התוומו ותפוופו	Be Completed by Physician/M	resulting in death)  Sequentially list conditions, if any, leading to immediate characteristics and in John Market Present Industrial Cause (Disease or injury that intiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1	b. Due  c. Due  d. 23c. If yes, 1 Liv 4 Pre 9 Un  tions contributing to LAR INSUF	to (or as a consect DYSPHAG to (or as a consect to (or as a consec	quence of):  iIA quence of):  quence of):  quence of):  anancy al death 3 [ death 5 [ sulting in the u  /  ER/Outpatier 28b. Time o Injury	nderlying cause give	26. Place of er: 4 🗆 Nursin v at	24a. Was autor performed to the control of the cont	obacco u Yes 2 an an any ormyd? 2 No one) dence (how injur	23d. Date of delive Month  Use contribute to the second se	Pery Year  the cause of death? bably 4 □Unknowr  posy findings available impletion of cause of 2 No
Oliector, page z situato de detacried los as tile bullar tialisti	edical Certification; To Be Completed by Physician/M	resulting in death)  Sequentially list conditions, if any, leading to immediate characteristics and in the past 12 months? 1 Sequentially leading to the past 12 months? 1 Sequentially leading to the past 12 months? 1 Sequentially leading to the past 12 months? 1 Sequentially leading to the past 12 months? 1 Sequentially leading to the past 12 months? 1 Sequentially leading to the past 12 months? 1 Sequentially leading to the past 12 months? 1 Sequentially leading to the past 12 months? 1 Sequentially leading to the past 12 months? 1 Sequentially leading to the past 12 months and 12 months are past 12 months are past 12 months and 12 months are past 12 months are pas	b. Due  c. Due  d. 23c. If yes, 1 Liv 4 Pre 9 Un  tions contributing to LAR INSUF  ting Hospital: 1 28a. Da (M)  ting Physicien: To- al Exeminer: On the	to (or as a consect DYSPHAG to (or as a consect to (or as a consec	quence of):  IA quence of):  quence of):  quence of):  ancy al death 3 [ death 5 [ sulting in the u  /  Zeb/Outpatier 28b. Time o Injury  nome, farm, strify)	nderlying cause give  nt 3 DOA Other  f 28c. Injury Work M 1 Creet, factory, office	26. Place of  ar: 4 □ Nursin  at  ?  Yes 2 □ No	24a. Was autor performed to the control of the cont	obacco u Yes 2 ( an Dosy Irmyd? 2 No Done) dence ( how injur Street an wn, State cause(s)	23d. Date of delive Month  Ise contribute to the second se	Tery Day Year  the cause of death? bably 4 Unknown  Dopsy findings available  and Poute Number,  stated.
S should be detactied for use as the burlat-transit	To Be Completed by Physician/M	resulting in death)  Sequentially list conditions, if any, leading to immediate course. Entail Industry, Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due  c. Due  d. 23c. If yes, 1 Liv 4 Pre 9 Un  tions contributing to LAR INSUF  ting Hospital: 1 28a. Da (M d not be ring Physicien: To al Exeminer: On the and m	to (or as a consect DYSPHAG to (or as a consect to (or as a consec	quence of):  IA quence of):  quence of):  quence of):  ancy al death 3 [ death 5 [ sulting in the u  /  Zeb/Outpatier 28b. Time o Injury  nome, farm, strify)	nderlying cause give  nt 3 DOA Other  f 28c. Injury Work M 1 Creet, factory, office	26. Place of er: 4 \( \text{ Nursin} \) vat \( \text{?'} \) Yes 2 \( \text{ No} \) No he, date and ploinion, death of	24a. Was autor performed to the courred at the time,	obacco u Yes 2 ! an ssy ormyd? 2 ! No one) dence (how injur Street an wwn, State cause(s) date and	23d. Date of delive Month  Ise contribute to the second se	Pery Day Year  the cause of death?  bably 4 Unknown  posy findings available  impletion of cause of  2 No  fy)  al Route Number,  stated. o the cause(s)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

December's Name (Frex Middle, Last)   Seed of Death Res. 24 - 2005   9.10	- St	or Amen egistrar	id I	teml8	.2&U	npend	I Ite	金面 23	sa, 24	eftificate o	Death		Reg. No.	<b>3.000</b>	2831
LEFRY   An Seathly shame of not residuation, pine stread and number												2. Date of D			3. Time of Dea
Security Name of Prince Instances, your street and number?  137 CLIARCHOON AVENUE  5. Social Security Number?  1.	J	JEFFR\	Υ			(	GREG	G			MASHKES			<del>,-2005</del>	9:31 P
Special processory   Number   Special processory							um <i>ber)</i>					th			
Usual Realization of Deceleration of Deceleration of Deceleration of Deceleration of Deceleration and States   100. Cliny Town or Location   110. Bit   100. Bit				lon A	venu	ıe	7. Age	(In yrs. la	ast birthda		r If Under 24 Hrs		irth	9. Bit	rthplace (State or Fo
100. Elizar   100. Cap / Senset and Namber   100. Cap / Senset and Namber   100. Elizar of What Country   100. Elizar of Eli				-	1 🔀 A	1 2□F				Months Day	s Hours Min	04/26/	1956	C	MD
MD   BALTIMORE   PIKESVILLE   100, 200 code   100, Class of What County   101, S. A.   110, Marcal Status   12, Was Expendent Ever in U.S.   13, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   11, Marcal Status   12, Was Expendent Ever in U.S.   13, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   11, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   11, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly Yes or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (Boogly West Or No.   12, Was Decedent of Hispanic Crigin? (B								10c City	Tours or	Location					10d, Inside City L
To a. Streat and Number  1 one. f Number  1 one. Streat and Number  1					MORE										1 [] Yes 2
13 / CLAREHOUN AVENUE   13. Was Deceder of Historic Origin?   Specify, yes on No- Historic Control of Hi										10f. Zip Code			10g. Citi	zen of What C	ountry?
Transport   Continue	1	L37 CI	LARE	NDON	AVE	ENUE				2120	8			U.S.A.	•
Type   Continue   Co	11. Ma	arital Status	5		12	. Was Der Armed F	cedent E	ver in U.S	S. 10	3. Was Decedent of	Hispanic Origin? ( Joan, Mexican, Pue	Specify Yes or N nto Rican, etc.)	lo-		
16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent's Education   16a   Decedent   16a   Decedent's Education   16a   Decedent					d	1 ☐ Yes If Yes, G	2.M∑No Sive	0		1 □ Yes 2 1 N	o Specify:			Specify:	WHITE
JERRY MASHKES GLORIA COHE    JERRY MASHKES   FATHER   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   JERRY MASHKES   FATHER   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   JERRY MASHKES   FATHER   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   JERRY MASHKES   FATHER   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   JERRY MASHKES   FATHER   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   JERRY MASHKES   FATHER   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   JERRY MASHKES   FATHER   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   JERRY MASHKES   FATHER   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   JERRY MASHKES   FATHER   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   Jerry Mash Call Code (Code)   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   Jerry Mash Call Code (Code)   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   Jerry Mash Call Code (Code)   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   Jerry Mash Call Code (Code)   190. Mailing Address (Sirved and Number or Plural Route Number, City or Town, State, Zer Code)   Jerry Mash Call Code (Code)   190. Mailing Address (Sirved And Number or Plural Route Number, City or Town, State, Zer Code)   Jerry Mash Call Code (Code)   190. Mailing Address (Sirved And Number or Plural Route Number, City or Town, State, Zer Code)   Jerry Mash Call Code, Service (Code)   190. Mailing Address (Sirved And Number or Plural Route Number, City or Town, State, Zer Code)   Jerry Mash Call Code,	3 [	_ widowed			s Educa		Dates.		16a. Dec	cedent's Usual Occ	upation		16b. Ki	ind of Business	s/Industry
JERRY MASHKES   GLORIA   COHE    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   FATHER   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity    JERRY MASHKES   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity   199. Maling Address (Sireet and Number or Plural Route Number, City or Town, State, Zer Codity   199. Maling Address	Flor		ecity or	lly highest		completed		F)	(Gi life	ive kind of work dor	ne during most of wo red)	orking			
JERRY   JERRY   MASHKES   GLORIA   COHE					<u> </u>	2			NON	<u>IE</u>	7		_1		
19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Costs)   19c. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Costs)   19c. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Costs)   19c. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Costs)   19c. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Costs)   19c. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Costs)   19c. Mailing Address of Pacifity   19c. Mailing Address of Pacifi			e (First	Middle, L	ast)			M	лсиис	- c			e, Maiden	Sumame)	COHEN
JERRY MASHKES   FATHER			Nama	Deletion ch	in Tun	o Orint)		141/					her City o	r Town State	
20a. Method of Disposition   Date   20c. Location - City or Town, State   1 20cmate)   20c. Location - City or Town, State   20cmates, cramatory or other place   0al / 28 / 2005   REISTERSTOWN, M   22. Name and Address of Facility SOL LEVINSON & BROS., IN   22. Name and Address of Pacility Sol Levinson															
1980   1980	100		-		' ''	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		20b. Pla	ace of Dis	sposition (Name of					
Sequentially list conditions, a window property light of the cause of the death of the cause o						moval fron	n State					8/2005	REIS	TERSTO	WN, MD
23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interview in the disease, or complications are condition on the caused in	21. Si	ignature of	Funera	Service L	icensee	,				00 11 141	trace of Eacility C	OL LEVI	NSON	& BROS	., INC.
Sequentially list conditions of the cause (in the cause of the cause o		150	25	_		-									
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Eetal death 3   Ectopic pregnancy   1   Live birth 2   Eetal death 3   Ectopic pregnancy   1   Live birth 2   Eetal death 3   Ectopic pregnancy   1   Live birth 2   Eetal death 3   Ectopic pregnancy   1   Live birth 2   Eetal death 3   Ectopic pregnancy   1   Live birth 2   Eetal death 3   Ectopic pregnancy   1   Live birth 2   Eetal death 3   Ectopic pregnancy   1   Live birth 2   Eetal death 3   Ectopic pregnancy   1   Live birth 2   Eetal death   1   Live birth 2   Eetal death   2   Live Birth 2	Imme diseas resulti	shock, or hediate Caus se or conditing in death	eart fail se (Fina ition h)	ure. List o	only one	ations that cause on Smoke	e inh	e. nalat u consequ	ion uence of):	8900 REI	STERSTOWN ying, such as cardi	ROAD -	PIKE	SVILLE	Approximate Interval Betwee Onset and Dea
24a. Was an autopsy performed?   24b. Wear and part of eath?   24b. Wear and pror to completion death?   25c. Was case referred to medical examiner?   25c. Was case referred to medical examiner   25c. Was case referr	Seque larry, cause Cause that in	shock, or hediate Caus se or conditing in death entially list, leading to be (Disease nitiated every series of the conditions of the condi	eart fail se (Fina ition h) condition condition derlying or injurents	ure. List o	a. b. c.	ations that cause on Smoke	e inho (or as a	e. nalat i consequ	uence of):	8900 REI	STERSTOWN ying, such as cardi	ROAD -	PIKE	SVILLE	Approximate Interval Betwee
24a. Was an autopsy find prior to completion degate symmetry.  25. Was case referred to medical examiner?  10	Seque disease resulting Seque de la cause Cause that in resulting le cause de la cause de	shock, or h didate Caus se or condi ing in deatl entially list , leading to . Enter Un entially list , leading to . Enter Un entially list , leading to . Enter Un entially list make the condition MALE: Was deced n the past 1 □ Yes	eart failse (Fina ition h)  condition condition condition deriving right of the condition o	ins, late	b. c. d.	Smoke Due to	e inho (or as a o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o to o (or as a o (or a) (or as a o (or a) (or as a o (or a) (or	nalat a consequ a consequ consequ pregnar pregnar pregnar	uence of):  uence of):  uence of):	8900 REI enter the mode of of and there	STERSTOWN ying, such as cardi nal injur:	ROAD -	PIKE arrest.	23d. Date of de	Approximate Interval Betwee Onset and Dea
25. Was case referred to medical examiner?    XXYes 2   No	Seque i any, cause Cause that in resulti	shock, or h diate Caus se or condi ing in deatl entially list placed in the past of the pa	eart failse (Finalition h)  condition condition derlyin or injur nits h) Last	ins, instead	b. c. d.	Due to	e inho (or as a o (or as a o o (or as a o o (or as a o o (or as a o o o o o o o o o o o o o o o o o	nalat a consequ a consequ a consequ consequ consequ consequ difference of pregnare	uence of):  uence of):  uence of):  ncy death eath	8900 REI enter the mode of of and there  3 Ectopic pregna 5 Other (specify,	STERSTOWN ying, such as cardi nal injur:	I ROAD - ac or respiratory ies	PIKE arrest,	23d. Date of do Month	Approximate Interval Betwee Onset and Dea On
25. Was case referred to medical examiner?    XXYes 2   No	Seque i any, cause Cause that in resulti	shock, or h diate Caus se or condi ing in deatl entially list placed in the past of the pa	eart failse (Finalition h)  condition condition derlyin or injur nits h) Last	ins, instead	b. c. d.	Due to	e inho (or as a o (or as a o o (or as a o o (or as a o o (or as a o o o o o o o o o o o o o o o o o	nalat a consequ a consequ a consequ consequ consequ consequ difference of pregnare	uence of):  uence of):  uence of):  ncy death eath	8900 REI enter the mode of of and there  3 Ectopic pregna 5 Other (specify,	STERSTOWN ying, such as cardi nal injur:	I ROAD - ac or respiratory ies	PIKE arrest,	23d. Date of do Month	Approximate Interval Betwee Onset and Dea
examiner?  NCXYes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence Cher (Specify) at 28d. Describe how injury occurred Work?  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  8-26-05  6:43 PM 1 Yes 2 No  Subject victim of house 28f. Location (Street and Number or Rural Route City or Town, State) 137 Clarend Pikesville, Md  29a. Certifier (Check only one)  29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number  29d. Date signed (Month, Day, Yes)  O.C.M.E.  August 26, 2	Seque i any, cause Cause that in resulti	shock, or h diate Caus se or condi ing in deatl entially list placed in the past of the pa	eart failse (Finalition h)  condition condition derlyin or injur nits h) Last	ins, instead	b. c. d.	Due to	e inho (or as a o (or as a o o (or as a o o (or as a o o (or as a o o o o o o o o o o o o o o o o o	nalat a consequ a consequ a consequ consequ consequ consequ difference of pregnare	uence of):  uence of):  uence of):  ncy death eath	8900 REI enter the mode of of and there  3 Ectopic pregna 5 Other (specify,	STERSTOWN ying, such as cardi nal injur:	I ROAD - ac or respiratory ies  23e. Dic 1 24a. We auti	PIKE arrest,	23d. Date of de Month  use contribute  No 3   F	Approximate Interval Betwee Onset and Dea Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea
27. Manner of Death	Immedisearresulti Sequeta il ary, cause that in resulti IF FEI 23b. Viii	shock, or hadiate Causses or conditing in death entially list in leading to the condition of the condition o	ieart fair ition condition con	ins, late gnant this?	b. c. d.	Due to	e inho (or as a o (or as a o o (or as a o o (or as a o o (or as a o o o o o o o o o o o o o o o o o	nalat a consequ a consequ a consequ consequ consequ consequ difference of pregnare	uence of):  uence of):  uence of):  ncy death eath	8900 REI enter the mode of of and there  3 Ectopic pregna 5 Other (specify,	STERSTOWN ying, such as cardin nal injur:	I ROAD - ac or respiratory i.es  23e. Dic 1□ 24a. We aui pei	PIKE arrest,  ditobacco u  Yes 2  Is an oppy formed? 2 □ No	23d. Date of do Month  use contribute  No 3 F  24b. Were a prior to degth?	Approximate Interval Betwee Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea
29a. Certifier (Check orly one)  29a. Certifier (Check orly one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Young)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Immedisear result if any, cause that in result if any, cause that in result if any, cause that in result if any in	was case recaminer?	eart fail e (Fina ition h)  condition or injuriant pre 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 12 month of 13 month of	ins, late gnant this?	b. c. d. 236	Due to	e inho (or as a o (or as a o (or as a o o (or as a o o (or as a o o (or as a o o (or as a o o (or as a o o o (or as a o o o o o o o o o o o o o o o o o	e.  nalat a consequ a consequ a consequ b f pregnar consequ consequ a conseq	uence of):  uence of):  uence of):  ncy death eath	8900 REI enter the mode of of and there  3 Ectopic pregna 5 Other (specify,	STERSTOWN ying, such as cardi nal injur:  ncy given in Part I.	23e. Did 24a. We au 124 Yes eath (Check only)	PIKE arrest,  it tobacco u  Yes 2  us an opsy 2 □ No	23d. Date of de Month  use contribute  No 3 F  24b. Were a prior to death?	Approximate Interval Betwee Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea
29a. Certifier (Check orly one)  29b. Signature and title of certifier  29b. Signature and detection of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Young)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Immediseasures result in any service of the service	diate Caus se or conditing in death entially list in entially list in entially list. Letter United the entially list in entially list. Letter United on the goisease with ential	eart fail ein hill ei	gnant ths?	b. c. d. 236	Due to	e inho (or as a o (or	nalat a conseque t conseque t conseque t conseque t conseque t not resue at not resue	uence of):  Jones	8900 REI enter the mode of c and there  3   Ectopic pregna 5   Other (specify, e underlying cause	STERSTOWN ying, such as cardinal injur:  al injur:  26. Place of D Other: 4   Nursing	23e. Did 24a. We au 124 eath (Check only Home 5 □ Re 28d. Describ	PIKE arrest,  d tobacco u lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 2 lyes 3 lyes 2 lyes 3 lyes 4 lyes 3 lyes 3 lyes 4 lyes 3 lyes 4 lyes	23d. Date of do Month  use contribute  No 3 F  24b. Were a prior to death?	Approximate Interval Betwee Onset and Dea Dea Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea
29b. Signature and title of certifier  29c. License number  O.C.M.E.  August 26, 2	Immediseau resulti Sequeti i arry, cause that in resulti IF FEI 23b. // ii ii 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	diate Causses or condition in death seed of conditions or	eart fail e (Fina ition in the fail of the	gnant ths?	b. c. d. 236 Ho	Due to  Co. If yes, of the present o	e inho (or as a o (or	a consequence of pregnar 2 Fetal time of delay at not result not r	ncy death ath lining in the ER/Outpai	8900 REI enter the mode of c and there  3 Ectopic pregna 5 Other (specify, e underlying cause	STERSTOWN  ying, such as cardinal injur:  al injur:  26. Place of D  Other: 4   Nursing  jury at vork?  Yes 2 (No)	23e. Diction of the second of	PIKE arrest,  It tobacco u  Yes 2  Is an opsy cone) sidence be how injuit (Street arrown, State	23d. Date of do Month  use contribute  No 3 F  24b. Were a prior to death?  175-Ye  tim of  nd Number or R  1137 C1	Approximate Interval Betwee Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset Indiana On
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Immediseau resulti Sequeti i arry, cause that in resulti IF FEI 23b. Viii 1 5 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	shock, or hiddate Caus see or conditing in death entially list in the seed of conditing in death entially list in the seed of cause in the past in the	eart fail ein h)  condition it in h)  condition in h)  c	gnant ths?  Description of medical conditions of medical condition	b. c. d. 236 Hons control	Due to Country Indiana Country	o (or as a o (or as a	nalat a conseque a conseque of pregnar 2 Fetal time of de ut not resu  ury - At ho c. (Specify examinat	uence of):  uence of):  uence of):  ncy death eath ath  ER/Outpai  28b. Time Injur  6:43  wledge, de	and there  and there  and there  Bettopic pregna  Compared to the content of the	STERSTOWN  ying, such as cardinal injur:  all injur:  all injur:  26. Place of D  Other: 4   Nursing  liury at Vork?  Yes 2 (**)  The stime, date and place of time, date and place of time.	23e. Dices  23e. Dices  23e. Dices  24e. We author per per per per per per per per per pe	PIKE arrest,  It tobacco u  Yes 2  Is an opsy cone) sidence the how injunct (Street arrown, State ille, the cause(s)	23d. Date of do Month  use contribute  No 3 F  24b. Were a prior to death? 175 Year  To Cher (Sp. 175 Year)  175 Year  175 Yea	Approximate Interval Betwee Onset and Dea Dea Onset and Dea Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea
	Immediseau resulti frequency frequen	MALE: Was deced in the past 1   Yes came?  //as case re camine?	leart fail and the condition of injury and the condition o	gnant ths?  Pending investig Cortifyin Medical I	b. c. d. 236  Ho gation not be ined  g Physic Examine	Due to  Custom   o (or as a	nalat a conseque a conseque of pregnar 2 Fetal time of de ut not resu  ury - At ho c. (Specify examinat	uence of):  uence of):  uence of):  ncy death eath ath  ER/Outpai  28b. Time Injur  6:43  wledge, de	8900 REI enter the mode of c and there  3   Ectopic pregna 5   Other (specify, e underlying cause  tient 3   DOA   e of 28c. In y Street, factory, offi	STERSTOWN ying, such as cardinal injur:  al injur:  26. Place of D Dther: 4   Nursing york?   Yes 2   No ce e time, date and pla y opinion, death oc	23e. Dices  23e. Dices  23e. Dices  24e. We author per per per per per per per per per pe	PIKE arrest,  It tobacco to lives 2 liss an loopsy formed? 2 liss an loopsy formed? 2 liss an loopsy formed? 3 list and list are listed arrest.  Is tobacco to live and list arrest.	23d. Date of do Month  use contribute  No 3 F  24b. Were a prior to death? 15 Ye  where (Sp  ry occurred  tim of d Number or P  137 C1  Md  and manner a d place, and di	Approximate Interval Betwee Onset and Dea Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea	
TNVA KUGIVINO III Penn Street. Baltimore. Marviand 21201	Immediseau resulti frequency frequen	MALE: Was deced in the past 1   Yes came?  //as case re camine?	leart fail and the condition of injury and the condition o	gnant ths?  Pending investig Cortifyin Medical I	b. c. d. 236  Ho gation not be ined  g Physic Examine	Due to  Custom   o (or as a	nalat a conseque a conseque of pregnar 2 Fetal time of de ut not resu  ury - At ho c. (Specify examinat	uence of):  uence of):  uence of):  ncy death eath ath  ER/Outpai  28b. Time Injur  6:43  wledge, de	and there  and there	STERSTOWN  ying, such as cardinal injur:  all injur:  all injur:  26. Place of D  Other: 4   Nursing  Jury at  Vork?  Ves 2   No  De be time, date and pla  y opinion, death oche ense number	23e. Dices  23e. Dices  23e. Dices  24e. We author per per per per per per per per per pe	PIKE arrest,  I tobacco u  Yes 2  Is an opsy rone) sidence e how injunct (Street arrown, State 111e, le cause(s) e, date and	23d. Date of di Month  use contribute  \[ \text{No} 3 \] \[ \text{F} \]  24b. Were a prior to death?  175 \[ \text{Yes} \]  175 \[ \	Approximate Interval Betwee Onset and Dea Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Dea Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea	
ate 31. Date filed (Month, Day, Year) 32. Registral's Signature	Immediseau resulti Sequel il arry, cause il arry, cause that in resulti IF FEI 23b. Vi ii 15 cause 12	diate Causses or conditing in death see or conditing in death see or conditing in death see or conditing in death see or conditing in death see or conditing in death see or conditing in death see or conditing in death see or conditing in death see or conditing in death see or conditing in death see or conditing in death see or conditing in the past of the see or conditing in the past of the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or conditing in the see or condition in	eart fail e (Final ititle) condition or injuring the first pre- lent pre- 12 mon or injuring the first pre- 12 mon state of the first pre- 12 mon state of the first pre- 12 mon state of the first pre- 13 mon state of the first pre- 14 mon state of the first pre- 15 mon state of the first pre- 16 mon state of the first pre- 17 mon state of the first pre- 18 mon state of the first pre- 19 mon state of	gnant ths?  I condition  Pending investig Could in determined to certifier the condition of person of the condition of the certifier the certi	b. c. d. 236  glation out be ined  g Physic Examine  who com	Due to Du	e inloop of or as a control of or as a control of or as a control of or as a control of or as a control of or as a control of or as a control of or as a control of or an area of or an	a consequence of pregnar 2 Fetal time of delatime of d	Lion Lence of): Lence	and there  and there  and there  and there  and there  and there  and there  be and there  contains a proper contains a	STERSTOWN ying, such as cardinal injur:  al injur:  26. Place of D Dther: 4   Nursing youry at York?   Yes 2   No be et time, date and pla y opinion, death oc ense number  ). C.M.E.	23e. Did 24a. We au 12 Yes eath (Check only Home 5 □ Re 28d. Describ Subject 28f. Location City or 7 Pikesv ce, and due to th curred at the tim	PIKE arrest,  d tobacco u  Yes 2  Is an opsy formed? 2 No Yone) sidence e how injurt (Street arrown, State ille, ie cause(s) e, date and	23d. Date of de Month  24b. Were a prior to death? 1,524e  24b. Were a prior to death? 25b. Were a prior to death. 25b	Approximate Interval Betwee Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset and Dea Onset on Onset on Onset On

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 28312 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** 7:43 24 64. 2005 aulINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROSEDALE SQUARE HOSPITAL CENTER BALTIMORE FRANKLIN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex A. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Months 1 M 2 D 80 Director 218-18-4887 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 1timore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21222 USA 612 AVENUE trood may Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 L If Yes, Give Year or Dates: 1 Never Married 2 Married 2 JH6 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 6 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gertrude Peter Emanuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of semetery, crematory or other place) Department of Health Important: If itam 27 Avenue Da Homore 20c. Location - City or Town, State JUSAN MCGOWAN Baltimore, Date 20a. Method of Disposition injury or Bradly-Ash ton 4 ☐ Donation 5 ☐ Other (Specify) 105 21. Sign ture Funeral Service Ligensee any in Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE RENAL FAILURE /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit to the Hospital or Attanding Physician: The law requires that the death certificate be executed URINARY TRACT Due to (or as a donsequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ ATRIALFIBRILLATION CHRONIC RENAL FAILURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes 2 🗌 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕻 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: I Director: After t d in by the funera 1 XNatural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To tha Funaral I 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05 30. Tame and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore, MD ZIZIZ 5415 Springlake Way Tilburt 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 3 0 2005

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ella Marie Murray 9:56 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LongView Nursing Home Manchester Carroll 8. Date of Birth March Tay, Year, 1915 Birthplace (State or Foreign Country)
 Nary Land If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2∰F 213-10-7769 Vrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f show treumetic event, the Madical Examinar must be notified at Marylan ! 1 ☐ Yes 2 ☐ No Carroll Director Manchester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3553 Water Tank Rd. 21102 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Sewing Factories permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked ofth any injury or other treumetic event. Size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Robert Rill Laura Virgina Ebaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Murray, Jr. - husband 3553 Water Tank Rd. Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State New Lutheran Cem. Aug. 29,2005 A □ Donation 5 □ Other (Specify) Manchester, Md. 22 Name and Address of Facility Ecknardt funeral 3296 Charmil Dr. 21. Signature of Funeral Service Licensee Chapel P.A. Manchester, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 051 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months
1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 Ho 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has autopsy performed? 2<del>□</del> No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide In Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tile of 29c. License number 29d. Date signed (Month, Day, Year) 33(6 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 ho fle cosen 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar AUG 3 0 2005

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28314 1- State
Registraamend item 35 PER INF G846 8 Penificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Robert E. Moran Jr August 14, 2005 3:10 AM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1514 Rolling Road Bel Air Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 219-34-1469 6 Sax **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ₹ M 2 □ F Director Yrs 69 Dec 7, 1935 Maryland Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Mudical Exercines must be notified at Director MD 1 ☐ Yes 2 ☑ No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 1514 Rolling Road Funeral 21014 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Marned 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 0 1 ☐ Yes 2 ☒ No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) golf professional 12 sports other 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file timent of Health and Mental Hytent: If Item 27 Is marked oth 17. Father's Name (First, Middle, Last) Be Robert Edward Moran Helen Cathernine Strassner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai once. 843 Bear Cabin Drive Forest Hill, MD Kelly Smith/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Ştate `4 ∑Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wad 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street morr Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused it shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metas Cancinoma ing leuns /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery ate has been signed by the atterpage 2 should be detached for a 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ot namous 2 🗆 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2001 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of dath 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel D Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year) AUG 3 0 2005

4. Levine

30/ Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Chanles St

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28315 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Allegany Cumberland Lyons Manor Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days West Virginia Feb 9, 1918 Director 87 217-28-9009 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evention at 1 ☐ Yes 2√ No Directo MD **Allegany** Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 Somerville Avenue #208 21502 USA Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white \$ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home 8 0 housewife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minnie Belle Ratliff James B. Swick ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. 14948 Crossmill Road Felton, PA 17322 Marvin McBride/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** estive /Medical Due to (or as a consequence of): Examiner Cardiomy o pa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 21€ No certificate has lirector, page 2 s 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending after death.

I Director: Af in by the fur 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier worsocher 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg WONSOCK SMIN MD 48 Tarm Terrace 31. Date filed (Month, Day, Year) 3 Registrar's Signature State AUG 3 0 2005 Registra

State of Maryland / Department of Health and Mental Hygiene  $2\,0\,0\,5$ 28316 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 500 AM ORTON icole /Medical 4c. County of Death 4b. City, Town, or Location of Death me (If not institution, give street and number) Examiner Baltimore ear If Under 24 Hrs. Center HOSDITAL 9. Birthplece (State or Foreign Country)
MARYLANN 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 215-73-8919 Usual Residence of Deceden 1□M 200 F Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ahow injury or other treumatic event, the Medical Exeminer must be notified at 1 No Yes 2 No BALTIMORE Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206. or Iteme 23a wood 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural; or item any injury or other treumatic event, the Medical Exercited 2002. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A NIA 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle, Last) Be Michael 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NORTON 20b. Place of Disposition (Name of cemetery, crematory or other place) DACTIMORE Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BACTI MORE, MD 21234. BUANS FUNCRACCHAPEL, 8800 HARFORD RD. nol Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications t shock, or heart failure. List only one cause ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** zina enterocolitis and /Medical 19 Chemia **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). The law requires that the death certificate be executed use as the burial-transit P.O. Box 68760. IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?

1 Yes 2/1 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2.2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 200 No To the Hospitel or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Mnpatient ဂ္ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1, XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deall To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2015 Registrar

State of Maryland / Department of Health and Mental Hygien 0 0 5 28317 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician**  $\mathbf{A}^{\mathsf{M}}$ Mary O'Shea 26, 2005 1:45 Irene Aug. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner OakCrest Care Center **Parkville** Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 96 Yrs. PA Director 220-36-8115 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23e or 28e-f show other treumatic event. Its Nedical Example must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8834 Walther Blvd. 21234 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nt sny injury or other treumatic event. Ite Media once. Elementary/Secondary (0-12) College (1-4or 5+) Librarian Library 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank McLaughlin Frances Corle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay O'Shea Morrone/Daughter 1212 Brook Meadow Dr. Towson, MD 21286 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition St. Thomas Catholic Church Cemetery September 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 16, 2005 Bedford, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performe 2□ No 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funerel C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certain 3 eath (Hem 23a) (Type, Print) 30. Name and address of person who completed cause of 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

176/05-145

			For State of Maryla    - State Registrer	nd / Depa <i>Cer</i>	artment of He rtificate of D	ealth and M <i>leath</i>		en <b>2</b> 005	28318
,	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Col Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	HUGUST	24 2005 4c. County of Dea	
	Examin	er	Northwest Hospital		Randal			Baltim	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 104 26	Year) 9. Bir	thplace (State or Foreign puntry)
	Director		220-22-9889 1 M AAF 80	O Yrs.			04 26	25	VA
1	how		10a. State 10b. County 10c. 0	City, Town or Lo					10d. Inside City Limits
of the	or 28a-f show	Director		Baltim	1		10	g. Citizen of What Co	1 Yes 2 No
	s 1 and 2 should be lied within 72 hours arief deall with life marying them 27 is marked other than "natural", or items 23a or 28a-1 show them 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be muitted at		10e. Street and Number 2121 Windsor Garden Lane	Apt B5	10f. Zip Code 14 Balt	imore	10	U.S.	
1	items 2;	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?		Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
3	or it	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 No Divorced 1 Year or Dates:	1	1 ☐ Yes 2 No	Specify:		Specify:	lack
	"natural",		15. Decedent's Education	16a. Dece	dent's Usual Occupat	ion	1	6b. Kind of Business	
7	ne. ne. "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	+	dent's Usual Occupat kind of work done du DO NOT use retired)			Md Cup C	ompany
7	Hygiene. Hygiene. other than "		12th grade na  17. Father's Name (First, Middle, Last)	Lin	e Worker		(First, Middle, M		Ompany
	ental h kad ol ic eve	To Be	Elmer Davis			Sarah W			
ם ک	z snould be fried wiffir and Mental Hygiene. is markad other than sumatic event, the M.	_	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street ar				
	Health Health Hem 27		David T. Phillips Jr-Son	Place of Disno	Kathyda			Oc. Location - City or	
5	permit. Pages 1 and 2 Department of Health 3 Important: if item 27 is any injury or other tra once.		1 Burial 2 Cremation 3 Removal from State	cemetery crem MaryIa	natory or other place nd State	}			
	permit. P Departme Importan any injuri once.		21. Signatore of Funeral Service Loense		y Board  2. Name and Addr s	8/29		altimore	
<u> </u>	Depa Impo any i		Nomana C. Vxug		Name and Address F F F			ore, Md	21215
			2 a Part 1. Enter the disease, or complications that ceused the degree of cock, or heart failure. List only one cause on each line.	ath. Do not ent	ter the mode of dying,	, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
F	hysician /Medical		Inhy diate Cause (Final def ase or condition resulting in death)  a. Due to (or as a cons		Above K	HEE AD	TOTUM	ON	
E	Examiner		C	A to 14P	IRY ART	ERY C	DISEAS	€ ′	
7	D ti	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):		/			
	xecute and al-trans	Examiner	resulting in death) Last  C. Due to (or as a cons	equence of):					
00/00	tificate be executed g physician and as the buriat-transit	edical E	d					ar acrete des	
00	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		IF FEMALE:						
ם ס	eath certift attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
<b>;</b>	t the dr by the ached	hysic	1   Yes 2   No 9   Unknown						
'n	es that gned t	by P	Part II. Other significant conditions contributing to death but not r	esulting in the u	inderlying cause give	n in Part I.			o the cause of death?
cords	requir						**		robably 4 Onknown
ည် မ	ne iaw s has b ge 2 s	Completed					24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
	an: Ti tificate tor, pa	0	25. Was case referred to medical	<u> </u>		26. Place of Deat	1 Yes 2	No 1 □ Ye:	s 2N No
5	Physician: r this certific ral director,	To B		☐ ER/Outpatier		4   Nursing Ho		nce 6 Other (Spe	ecify)
	ding P	ion:	27. Manner of Death  ∑Natural 5 ☐ Pending  ☐ Accident investigation	28b. Time of Injury	Work		28d. Describe hov	w injury occurred	
DIVISION	Attendra death	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - Al	t home, farm, str		-	28f. Location (Str. City or Town,	eet and Number or F	lural Route Number,
5	tal or rs afte al Dir	Cert	4 Homicide determined building, etc. (Spe				- Only of Youri,		
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death statements after death statements for the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	edical	29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of exam and manner stated.						
	ro the vithin 2 ro the comple	Med	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Mon	th, Day, Year)
	/		> goginder P Michta m	1.0	D41		U	ugust 24	2005
	5		30. Name and address of person who completed cause of death (I	tem 23a) (Type,			MEHTA		
	Sta	ato.	31. Date filed (Month, Day, Year)  32 Registrar's Sig	TER mature	RANDA	USTOWN	no.	21133	•
	Registi		AUG 3 0 2005 Marie	J. A.					

			For State Registrar	State of Ma		artment of He			ene 200	5 28319
3	Physici /Medic		1. Decedent's Name (First, Middle, La		1USKAS			2. Date of Death Month AVQVSF	27, 200	5 0432 M
-	Examir Funeral	_		HOSP	(In yrs. last birthday		ore If Under 24 Hrs.	8. Date of Birth	4c. County of De	irthplace (State or Foreign
je.	Director		Usual Residence of Decedent	1□ M 20 F	90 Yrs.		Hours Min.	(Mopth, Day, Y 8/2/19	15	OCILY, TTALY  10d. Inside City Limits
Maryland 21215-0036	he Maryla 28a-f shov	ector	mo	2. Citizen of What (	1 ☐ Tes 2 ☐ No					
	hould be filed within 72 hours after death with the Maryland Mental Hygiene.  marked other than "natural", or iteme 23a or 28a-f show marked other than "natural", or iteme 23a or 28a-f show marke event, the Muculcal Exaci	Funeral Director	10e. Street and Number  6401 Loch RAVE  11. Marital Status	BLVD.  12. Was Decedent E Armed Forces?	Apr. 330 ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	739 panic Origin? (Sp Mexican, Puerto		USA 14. Race - An Black, Wh	nerican Indian,
		þ	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's E	1 Tes 2 N If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2 ☐ No	Specify:	16	Specify:	HITE
		Completed	(Specify only highest gr	College (1-4or 5	life_	e kind of work done dur DO NOT use retire	57	-	BEAUT	ICIAN
		To Be	17. Father's Name (First, Middle, Las.  19a. Informant's Name/Relationship	Conso	19h Mail	ing Address (Street and	VEN	e (First, Middle, Ma CENZA ral Route Number, C	CON	KNOWN)
	ges 1 and 2 should it of Health and Men if Item 27 is marke or other traumatic		AIBERTA HENS 20a. Method of Disposition 1 Burial 2 Cremation 3	EC - DAUG	hter 97	osition (Name of amatory or other place)	ZOB CE	Date 20	TMORE,	m0 21234 or Town, State
Baltimore	permit. Pag Department Important: I any injury o		4 Donation 5 Other (Special Signature of Funeral Service Lices	A	m∈m	ORIAC GARD 12. Name and Address 3800 HA		IANS FY	IMONIUM NERAL ARKVILLE	HUME
	Physician		23a. Part I. Enter the disease. In the shock, or heart failure. It stonly Immediate Cause (Final disease or condition resulting in death)	police ichs that caused y on you use on eich lin a.	the death. Do not er e.	iter the mode of dying,	such as cardiac	or respiratory arres	- tim	Approximate Interval Between Onset and Death
4	/Medical Examiner	er	1	b. Due to (or as a	a consequence of):	Arte	-y 6	115Eas-	e	
Division of Vital Records, P.O. Box 68760,	cate be executed oblysician and the burial-transit	Examin	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):	dente	Ve:	ssels		
	death certifii e attending p ad for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions	contributing to death bu	at not resulting in the	underlying cause given	in Part I.			to the cause of death?  Probably 4 Ourknown
	ding Physician: The n. After this certificate h funeral director, page	Completed						24a. Was an autopsy performe	prior to death?	autopsy findings available o completion of cause of es 2 \( \) No
		ation; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1  Inpatie  28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injury a Work?	4 Nursing H	th Check only one ome 5 Residence 28d. Describe how		pecify)
Divis	i Dife	Certification:	3 Suicide 6 Could not determined		iry - At home, farm, s :. (Specify)	treet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or i ted.	nvestigation, in my opin	nion, death occur	red at the time, date	e and place, and d	ue to the cause(s)
)	1	Z	29b. Signature and title of parties	M	Jahr	29c. License r	5857	<b>D</b>	E - 27	nth, Day, Year)
1	VQ Str	ate	30. Name and address of person who TENNANCE BUKE 31. Date filed (Month, Day, Year)	completed cause of do  7 MD 56  32. Registra	eath (Item 23a) (Type O LOCH Ir's Signature	29c. License r 000. Peint) Raven Blv	ld, Ba	Himore	MD 2	1239
	Regist		AUG	3 0 2003	Berein D	· Sparles				

ORIGINAL

Rose Petrayskas

State of Maryland / Department of Health and Mental Hygien 2005 28320 For State Registra Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Pottillo, Jr. Month Day Year D. **Physician** Melvin 2:10a M 22 8 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Casey House Montgomery Silver Springs Date of Birth (Month, Day, 3-14-5. Social Security Number Birthplace (State or Foreign Country) Sex 14 M 2 ☐ F 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 215-40-4745 Ok 61 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show other treumatic event, the Medical Examinar must be notified at ATXes 2 No Montgmery Silver Springs Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours efter death with ton of Health and Mental Hygiene.
ant: if item 27 is marked other then "netural", or items 23e or? 10112 Gladstone Street 20902 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐X/es 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Management Elementary/Secondary (0-12) Physical College (1-4or 5+) Facilities 12th grade Electrical Design Engineer 4yrs. Howard University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pottillo, Sr. Melvin Ruth Goosby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Pottillo Wife 10112 Gladstone St., Silver Springs, Md. 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State • <u>=</u> ŏ permit. Page Department of Importent: if eny injury or once. □ Donation 5 □ Other (Specify) 8-30-05 Owings Mills, Md. Garrison Forest Vet! 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 Do lad an March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No Division of Vital To the Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospice 1 ☐ Yes 2 X No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death 28b. Time of Certification; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ determined 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and till of Name and address of person who completed cause of death (Item 23a) (Type, Print) HX) arri 125 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Κ.			~		ype or Prir											
.CH	AEL POW	ER	S State Unpo Registrer	end It <b>em</b> 2	State of Ma 23a,27,28a	aryland a-f pe	d/Depa e <b>r ne</b>	artment G847 rtificate	of He 9-12 of L	ealth and -05 tas Death	Mental Hyg	giene 0	05	283	21	
	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of Death Year Year					
	/Medic	al	Michae  4a. Facility Name (I	f not institution, give s	Powers			4b. City, T	Fown, or	Location of Deat		5. 25, 2005 11:41 AM				
	Examir	ier	JOHNS HO	OSPITAL HO	SPITAL					ORE CIT	Y .					
	Funeral Director		5. Social Security Number 5. Social Security Number 1. Age (In yrs. last birthday) 1. Months Days Hours								Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Florida)  North Pay 1995  Florida					
	yland		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d.									0d. Inside City L	_imits			
	e Mar Ba-f st	ctor	Florida Seminole Casselberry								1  Yes 2 No					
	4 within 72 hours after death with the Maryland jene. r than "naturel", or Items 23s or 28s-f show the Medical Evanther must be multied at	Dire	10e. Street and Number   469 Triplett Lake										What Count  Stat	-		
		Funeral Director	11 Marital Status 12 Was Decedent Ever in U.S.					13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian, Black, White, etc.			
36	or its	by Fu	Armed Forces  1 Never Married 2 Married 1 Yes 2 No 1 Widowed 4 Divorced Year or Dates:				o 1 ☐ Yes 2 No Specify:				Specify: White					
9	2 hour		15. Decedent's Education					dent's Usua	l Occupa	tion	16b. Kind of Business/Industry					
215	within 73 ene. than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)					(Give kind of work done during most of working life. DO NOT use retired)  Dependent					Not Self Supporting			
d 21	filed wil Hygien other the	To Be Cor	17. Father's Name	Depei	ident		18. Mother's Na	me (First, Middle,	Idle, Maiden Sumame)							
lan	e d in b		Michael	۸.	Libby Chris					stina M. Ray						
Maryland 21215-0036	12 sho and r is m	3	19a. Informant's Name/Relationship (Type, Print) Cheryl Hall, Grandmother  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 469 S. Triplett Lake Drive, Casselberry, FL 32707													
Baltimore,	Pages 1 and ment of Heeltt ent: If Item 27 ury or other t		20a. Method of Disposition  1 Description 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Oaklawn Memorial Park  20c. Location - City or Town, State  August 31,2005 Sanford, Florida													
Balt	permit. Page Department of Importent: If any injury or		21. Signature of Fu	in-rol Service Ucons		01113					Banfield 434, Win				708	
	Physician /Medical		23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death													
			Immediate Cause (Final disease or condition resulting in death)  Asphyxia by Hanging  Due to (or as a consequence of):													
	Examiner		Comments the line	addison II		a consequ	erice or,									
	slt s	iner	Sequentially list conditions, fig. 19 and 19													
	be executed icien and burial-translt	Examiner	that inflated events resulting in death) Last C Due to (or as a consequent					nce of):								
68760,	te be e ysicier ne buri				d											
x 68	eath certificete be executed ettending physicien and for use as the burial-transit	Physician/Medical	IF FEMALE:		22 o lá vez euterme	c. If yes, outcome of pregnancy										
Вох	ettend for us	cian	23b. Was decedent pregnant   23c. If yes, officione of pregnancy   1								23d. Date of delivery  Month Day Ye			ar		
P.O.	of the de by the teched	hysi	9 Unknown 9 Unknown													
	res the igned be de	۵	Part it. Dities significant conditions continuously to death out not resolving in the underlying cause given in Part i.									co use contribute to the cause of death?  2 □ No 3 □ Probably 4 □ Unknown				
örö	sicien: The law requires thet the death certificete certificate bes been signed by the ettending phys rector, page 2 should be deteched for use as the	eted										24b. Were autopsy findings available				
Records,		Completed								autop	autopsy prior to completion of cause of death?			se of		
Vital		BeC	25. Was case referred to medical  26. Place of Death (Check only one)										163	20140		
of V	this aldi	1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other									)					
O	ding f th. : After s tuner	tion	27. Manner of Deat  1 □Natural  2 ▼Accident	5 Pending investigation	(Month, Da	(Month, Day Year)		at [	8c. Injury Work 1 🔲 Y	vork? □ Yes 2 👿 No	Subject					
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)			P			28f. Location (Street and Number or Bural It City or Town, State) 7899 Mt.			Poute Number	Road	
۵	urs afte ral Din		Residence							Meyersdale, Pennsylvania						
	Hospital 24 hours a Funeral i stely filled	edical	29a. Certiflier  (Check ority one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check ority one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
2 1	within 2 To the I	₩ W	29b. Signature and			0			. License			29d. Date sign				
			Talvillali Al. O.C.M.E AUG. 26,2005													
			30. Name and add	ress of person who co	ompleted cause of c				FT	ВАТЛТМО	RE, MARYL	AND 212	 01			
	Sta	ate	31. Date filed (Mor		32. Region				,		9 - W 3 & 1 - L L L L L L L L L L L L L L L L L L	3111 414	<u></u>			
	Regist	rar		AUG 3 0 20	005	ue.	K A	God								
DH	HMH 17 Rev 1/2	2001					ORIGI	ΝΔΙ								
							011101	47 Vin								

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar 28322 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 2005 /Medical 4a. Facility Name (If not institution, give street and number) own, or Location of Death Examiner JOHNS POKINS HOSPI TAL HIMORE CIT Social Security Number 3. Date of Birth (Month, Day, Year) Sept. 9, 1913 Maryland Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-28-8043 1 □ M 2 1 F 91 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23s or 28e-f show the Madical Examiner must be notified at Baltimore Funeral Director MD Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 7753 Baltimore Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3€N/idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 11th Pages 1 and 2 should be filed without of Health and Mental Hygie out: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Meyer Schwartz Goldie Cohen treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia S.Pecora 7753 Baltimore Street Baltimore MD 21224 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State = 5 8/31/05 permit. Page Department of Importent: If any injury or once. Baltimore MD OakLawnCemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Homeof Essex21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part 1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pnysician INFARCTION disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Dav Month Year 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient the tuneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Watural after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospitel 24 hours a Ecertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the M. Burness, MEDICAL DOCTOR RES-000 August 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOIFE St. BAltiMORE, MD 21287 BURNESS, GOD NORTH State Registrar

State of Maryland / Department of Health and Mental Hygien 05 28323 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** PETERSON 235 AM 2005 AUGUST HERESA /Medical 4b. City, Town, or Location of Death Buttimes 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 15505 HOPKINS RAYVIEW CRELLE DI If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) CITY BAYVIEW CARE CENTER BALTIMORE JOHNS HOPKINS Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔯 F 76 Yrs. Director October 9. 213-26-4852 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits "netural", or Itams 23a or 28e-f show ofical Examiner must be notified at 1 √Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If item 27 Ia marked other than "netural", or Itams 23a or 2 3015 Eastern Avenue United States 21224 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ John Smutek Helen Prusko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 l 3015 Eastern Avenue, Baltimore, Maryland, 21224 Florian Peterson-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Rosary Cemetery 08/27/2005 Baltimore, Maryland 21. Signature of Funeral Service Ligensee David J. Weber Funeral Homes, P.A. 23a. Part 1. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Friysician CARDIAC ARRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** CORUNARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter for u Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 1 Yes 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HYPERTENSION DIABETES 1 Yes 2 No 3 Probably 4 Unknown DYSLIPIDEMIA Be Completed MELLITUS 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? ATEIAL FIBRILLATION cate has rmed? 2 No certificate 2□ No 1 Yes 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MI Fridharan 00063164 2005 AUGUST 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCIDHARAN MOPKINS BATVIEW CIRCLE ANIRUDH 5505 BALTIMORE, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 2005 Registrar

Amend item#29d, perffD G846 8/30/05 TT
State of Maryland / Department of Health and Mental Hygien 2005 28324 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Daphne 10:50 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Hopkins The Johns HOS Sultimore City pital 5. Social Security Number Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 💢 F -46-1268 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be nutified at 1 No 2 No Director Timor 10e. Street and Number 10g. Citizen of What Country? Items 23a 0 To Be Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent Ev Armed Forces? 1 Yes 2 Volo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced "natural", Decedent's Education fy only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working ite. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. ary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health itam 27 I 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Arrhythmia Day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 🔲 Probably Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No this certificate 2 No 1 Yes or Attanding Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No 1 Inpatient Other: 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 27. Manner of Death 28h Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation М 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinat: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 26,2005 August RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe Street, Baltimore Sahera ,600 North Mustapha 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 3 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28325 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Carroll 625 AM 26 2005 lua /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. University of 5. Social Security Number Maryland Medical Conter If Under 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218-36-2980 Usual Residence of Decedent Days Hours **Director** with the Maryland 10a. State 10c. City Town or Location or Itema 23a or 28a-1 show 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No **Funeral Director** Himore 10e. Street and Number 10g. Citizen of What Country? 21133 ISA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Marital Status 1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1□Yes 2□**X**o Specify þ 3 Widowed 4 Divorced Black "natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Heath and Mental Hygiene. Important: If item 27 Ia marked other than any injury or other traumatic event, tra Ma Elementary/Secondary (0-12) College (1-4or 5+) pervisor moroveme 17. Father's Name (First, Midelle, 18. Mother's Name (First, Middle, 2 Hams lmand mant's Name/Re Istown, MD 21133 20b. Place of Disp sition (Name of cemetery, cren atory or other) 20a. Method of Disposition 20c. Location - City or Town, State atory or other place Burial 2 Cremation 3 Removal from State Baltimore 5 Other (Specify) ure o Funeral Service Licers uneral Services Randalletown, mD 2/133 23a. Part1. E te the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death as cardiac or respiratory arrest, Immediate Cause (Final Physician Congestive Heart disease or condition resulting in death) /Medical Due to as a consequence of) Examiner Loronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 ☐ Yes 2 ☐ No 3 probably 4 □Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed? this certificate 2 10 1 Yes fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 🗌 Yes 2 THO 1 Impatient 2 ER/Outpatient 3 DOA Director: Alter that in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funeral 6 1 Detrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier

DHMH 17 Rev 1/2001

4

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Kichard Ericson,



South

Hug

Green Street; Baltimore, MM

State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death 28326 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 24, 2005 Physician 11:00PM Charles Joseph Poole /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 10, 1931 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) al Security Number **Funeral** Days 1**∑**M 2□F Hours Yrs. Director 213-28-2448
Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or item any injury or other traumatic event """." 2133 White House Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes, Sime Year or Dates: 1950–57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 3 Computer Systems Analyst U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Heuisler Poole, Sr. George Cassandra Marie Harkins 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwyndolyn G. Poole - Wife 2133 White House Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 8/29/05 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Made 50 West Broadway Street, Bel Air, MD 21014 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or s a consequence of) Examiner b. Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Emphysema.

Due to (or as a consequence of): Hynoxaemia that initiated events resulting in death) Last by Physiclan/Medical Renal failure IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Bladder Carcinoma 1 Yes 2 No 3 Probably 4 Unknown Certification: To Be Completed From Small I testine Resection. 24b. Were autopsy findings available prior to completion of cause of death? Syndrome 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one. Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the P 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 82 D00 18424 Aug. 25, 2005 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1908 HARFORD ROAD, FALLSTON MD. 21047 B. PAREKH MD. 31. Date filed (Month, Day, Year) Registrar's Signature Registrar AUG 3 0 2005 DHMH 17 Rev 1/2001

**ORIGINAL** 

			•	State of Maryland / Department of Health and N  State Certificate of Death		en <b>2</b> 005	28327
				Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
		Physici		Nancy Ellen Powell	August 2	26, 2005	20:30 M
		/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of De	
		LXum		Upper Chesapeake Medical Center Bel Air		Harfo	rd
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign country)
		Director		212-46-4998 1 Months Days Hours Min.	Aug. 4,	1946 II	linois
		pu 🖈		Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or Location			10d. Inside City Limits
		aryla shov	٦				1 ☐ Yes 2 XNo
		Ne M	Director	Maryland Harford Edgewood  10e. Street and Number 10f. Zip Code	10.	g. Citizen of What C	
		with t	Ö		109	USA	ountry:
		death with the Maryland ms 23a or 28e-f show r must be notified at	Funeral	3048 Ebbtide Drive 21040  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Arr	erican Indian.
		ter d	Ë	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	Rican, etc.)	Black, Wh	
	336	urs al	by	3 ☐ Widowed 4 ☐ Divorced		Specify:	USA
0	9-0	2 hor	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation	ring 10	6b. Kind of Busines	s/Industry
3	21	thin 7 Bin "r	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  Elementary/Secondary (0-12) College (1-4or 5+)			
Ö	21	ad wi	Con	12 Auto Theft Investigator		Insuranc	e
X	nd	be filk tal Hy d oth	Be		e (First, Middle, Ma		
9	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Exacting must be notified at Once.	2	Paul Allison Bartlebaugh Eula	Belle	Moore	7.01
	Mar	and rand		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run		000000000000000000000000000000000000000	
h		1 and Health		John W. Powell / Husband 3048 Ebbtide Drive, Ed		Mary Land Oc. Location - City o	
0	آور	ages intoff interior		To Buffal /2 Cremation 3 Pemoval from State		altimore,	
1901	Baltimore,	it. Partmer rtent njury				uneral Ho	-
B	Ba	permi Depar Impo any ir		1317 Cokesbury Roa			
9				23. P. 11. Ent. the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac			Approximate
		Dhysisian		shock, or heart failure. List only one cause on each line.	car		Interval Between Onset and Death
	7	Physician / Medical		disease or condition resulting in death)  Due to (or as a consequence of):	curc		
	В	Examiner					
	4		ē	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	V	executed n and al-transit	Examiner	Cause (Disease or injury that initiated events c.			
	0,	e exe ian a urial-t	E	resulting in death) Last Due to (or as a consequence of):			
	8760,	cate be executed physician and the burial-transit	dicai	d			
1	9	certific nding p	0	IF FEMALE:			
K	Вох	death co	lan/	23b. Was decedent pregnant in the post 13 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of d	elivery Day Year
>	0	w requires that the death certifit been signed by the attending I should be detached for use as	Physician/M	1   Yes 2   No 9   Unknown   Unknown   The past 2   No 9   Unknown   Unknown   Unknown   Unknown   1   Yes 2   No 9   Unknown   Unknown   Yes 2   Yes			
0	α.	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
	ecords,	uires sign d be	d by		14 Yes	s 2 □ No 3 □ F	robably 4 DUnknown
#	Sor	v requestration	ete		24a. Was an	24b. Were a	autopsy findings available
,	Re	2 2	Completed		autopsy perform	ed? prior to death?	autopsy findings available completion of cause of
7	<u>_</u>	sicien: The certificate rector, pag		25. Was case referred to medical 26. Place of Deal	1 Yes 2		s 2 No
20	Vita	Physicien: this certific ral director,	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho			ecity)
9	of	g Phy er thi		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		
5	ion	ath. r: Aft	atio	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
=	Division	r Atte er de recto by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town,		Rural Route Number,
0)		ital o rs aft rel Dj	Cer				
Powell, Nanc		To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur			
()0		the the mblel	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number	290	d. Date signed (Mor	nth/. Dav. Year)
		Z 3 7 8		BM D 54841		8/271	05
		0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 -1	-
		10		Ashkan Bahrani, MD 8114 Sandpiper Circle, Sta	- 211 Ra	Itimasa 1	10 21236
		St	ate	31. Date filed (Month, Day, Year) 32. Hamistrar's Signature	ini judi	i illione,	12 2011.20
		Regist		AUG 3 0 2005			

State of Maryland / Department of Health and Mental Hygien 200528328 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** EDWARD PETERSON 11:30 AM 27 2005 AUGUS T /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 518 FAIRVIEW AVE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) JUNE 13, 1 **Funeral** Months 1 □ M 2 □ F Days Hours Min. Director <u>219-05-1626</u> 83 MD. Usual Residence of Deceden death with the Maryland show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or items 23e or 28e-f shov the Modical Examinar must be notified at Director 1 Yes 27 No MD. BALTIMORE EASTVIEW 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 518 FAIRVIEW AVE. 21224 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natureli, or ite ☐Yes 2☐No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐XNo Specify: WHITE þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH TAILOR SUIT MANUFACTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM PETERSON TINA ANTONINA KARASINSKA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: if Item 27 is any injury or other treu once. CLARA PETERSON/SISTER 518 FAIRVIEW AVE., BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ST. STANISLAUS CEM. 8/31/05 BALTIMORE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE? MARYLAND 21224 23a. Part1. Enter the disease, or co shock, or heart failure. List an Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death cause on each line 1 Immediate Cause (Final **Physician** dementiq disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. physicien s the buria Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year signed by the a d be detached for 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably CHRONIC URINARY RETENTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION autopsy rmed? 2 No HISTORY OF CEREBROVASCULAR 1 CCIDENT 1 ☐ Yes 1 🗆 Yes Division of Vital To the Hospitel or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Wesidence 6 Other (Specify) 1 □ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Thomicide filled within 24 hours a

To the Funerei C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) AUGUST 29 2005 D0062032 30. N-III e an address of person who completed ause of death (Item 23a) (Type, Print) Bayview Circle Baltimore MB 21234 5505 Hayashi MD 31. Date filed (Month, Day, Year) 32. signature State AUG 3 0 2005 Registrar

28329 1 - State G846 8/31/05 JH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4.33AM 106037 20 2005 Fumiko Price /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Doctor's Community Hospital Lanham
If Under 1 Year | If Under 24 Hrs. Prince George's Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2☑F Yrs. Director <del>Japan</del> Korea July 31, 1940 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other treumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk 2126 Alice Avenue #202 USA 14. Race - American Indian, Black, White, etc. Acian 20745 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 🙀 ivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Retail Sales unk-Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk ·unk Takeshi Fukushima **Kiyoko** 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Goro Fukuchima/brother 192 Morinosato, Atsugi Kanagana, Japan 20b. Place of Disposition (Name of Date Unic 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial XX Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☑ Other (Specify) in State Sept 8,2005 Edgewater, Md. Kalas Crematory George P. 21. Signatury of Funeral Service Ronald nans 21201 6160 Oxon Hill RD Oxon Hill Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate 110 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coasulops thy with /Medical Examiner Adeno (as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit - 44Q Cancer Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nespira lory autopsy performed? 2 No 1 Yes 2[] No 1 ☐ Yes hour ic 25. Was case referred to medical examiner? I or Attending Physicien: after death. Director: After this certific 26. Place of Death (Check only one, Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Yes 2 XNo 1 XInpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Late of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive 31. Date filed 32 Registrar's Signature (Morth, Day, Year) State 0 2005 Registrar

			For State Registrar	State of Maryland	/ Depart	ment of He	ealth and Me Death	ntal Hygie		5	283	30
			Decedent's Name (First, Middle, Last	t)			2	. Date of Death		ear 3	. Time of D	eath
	Physici /Medic		Doreen	Price			1	terest	24 26	rs	1107	AM
	Examin		4a. Facility Name (If not institution, give	street and namber)	41	-	Location of Death	0	4c. County of	Death		
			5. Social Security Number 6. Sec	ex 7. Age (In yrs. last	t hirthday)	Under 1 Year	If Under 24 Hrs. B			. Birthplace	/State or	Fomian
١.	Funeral Director		217-11-6534	□ M 20XF 7. Age (117 y.s. 7ast		onths Days	Hours Min.	Date of Birth (Month, Day, Ye	ar) 30	Country)	i/A	roreign
			Usual Residence of Decedent					_ / 1	501		VA	
	arylan ahow dat	_	10a. State 10b. County	10c. City, T	Fown or Locati	on					Inside City	
	Ba-f	Funeral Director	MD.			time	ore				/\	
	with the	Ö	10e. Street and Number	1		10f. Zip Code		10g.	Citizen of Wha	at Country?	,	
	ns 23	eral	3800 W. Bely  11. Marital Status	12. Was Decedent Ever in U.S.	13. Was	Decedent of His		fv Yes or No-	14. Race -	American I	ndian.	
9	ours after death with the Marylan ral', or Itams 23a or 28a-f show Examirer must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2 No If Yes, Give			panic Origin? (Speci , Mexican, Puerto Ric	cán, etc.)		White, etc.		
5-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show liteal Examirer must be natified at	Completed by	3 Widowed 4 □ Divorced	Year or Dates:	10	Yes 2 No	Specify:		Specify:	B19	CK	
	n 72 h	ete	15. Decedent's Ed (Specify only highest gra	ucation 1 de completed)	(Give kind	's Usual Occupat d of work done du NOT use retired)	tion <i>tring m</i> ost of working	166	. Kind of Busin	ness/Indust	ry	
2121	withir ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	me. DO	Labo			101		100	
	i filed I Hygi othar ant, I	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name (/	First, Middle, Mai	den Sumame)	4710	1	
Maryland	should be filed within 72 hours after dea Mental Hygiene. marked other than "natural", or Itams: matic evant, it e Midter Eximiter in	To B	Henry Do	abney			mart	ha	Nic	ho	las	
lar)	2 sho and h is ma		19a. Informant's Nam - Relationship (7		19b. Mailing A	ddress (Street ar	nd Number or Rural F	Route Number, Ci	ty or Town, Sta	ite, Zip Cod	de)	8
	r t z je d				1907 e of Disposition		rose,		Bal		212	23
õ	iges to the state of the state		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	etery, cremato	ory or other place	)		. Location - Cit			
Baltimore	permit. Pages 1 ar Department of Hea Important: If itam any injury or otha once.		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>			Zion ame and Address	of English	-05 E		mos	e , (	0.
Ba	permii Depar Impor any ir		1/20002	Hunter	Da	rrell	T. Hur	ter 1		Ba Ha	201	221
			23a. Part 1. Enter the disease, or com	plications that caused the death.	Do not enter the	ne mode of dying,	such as cardiac or r	espiratory arrest,	,		proximate erval Betwe	271
	Pnysician:		shock, or heart failure. List only Immediate Cause (Final	0 1		c. /.	1			On	erval betweenset and De	eath
	/Medical		disease or condition resulting in death)	aDue to (or as a consequen	nce of):	CMU	ga_				47.	
Е	Examiner	,	Sequentially list conditions.	b								
	be sit	inei	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):							
	xecut and	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequen	nce of):		·					
8760	ate be executed physician and the burial-transit	dical E	(	d.								
9	rtificat ng phy as th		Is service									
Вох	death certific e attending p od for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy		topic pregnancy			23d. Date o		y Ye	25
	that the death certific ed by the attending p detached for use as	Completed by Physician/Me	1 Yes 2 No	4□Pregnant at time of deat 9□Unknown	th 5 □ Ot	her (specify)			MORITI	Day	, 10	aı
P.0	requires that the wen signed by th hould be detache	Phy	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the unde	riving cause giver	n in Part I.	23e. Did tobac	o use contribu	ute to the cr	ause of dea	ath?
ds,	w requires that been signed b should be deta	d by	Ennh	Cens - IN	16 5	fred :		1 ☐ Yes		Probably		
CO	> 12 0	lete	Del	Les	3	+		24a. Was an	24b. Wei	re autopsy or to comple	findings av	ailable
Re	e la has je 2	omp		Pes		<u> </u>		autopsy performed 1 Yes (2)	? dea	r to comple th? Yes 2□		ise of
ita	i <b>cian:</b> Th certificate rector, pag	ψ.	25. Was case referred to medical				26. Place of Death (			183 2	1140	
Į (	Physician: this certific ral director,	To B	examiner2 1 ☐¥es 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient	3 DOA Other	. 4 Nursing Home	5 Residence	6 □Other	(Specify)		
0 0	ing PI After th	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury Work?	?	d. Describe how i	njury occurred			
isio	tend death. tor: A	icatl	2 Accident investigation 3 Suicide 6 Could not be		e form others		es 2 No	f. Location (Stree	and Number	or Dural Da	usto Alcombo	
Division of Vital Records,	or Al after of Dirac	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, rarm, street,	factory, office	201	City or Town, S		ar Hurai Ho	ute Numbe	ar,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funaral Diractor: After this certific completely illed in by the funeral diractor.	al C	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my knowle	edge, death oc	curred at the time	e, date and place, and	d due to the caus	e(s) and mann	er as stated	d.	
	ne Ho na Fui	Medical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	n and/or invest	igalion, in my opi	nion, death occurred	at the time, date	and place, and	I due to the	cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	0.		29c. License		29d.	Date signed (A	Aonth, Day,	, Year)	
	0		rani/ w	un.		1700	21730		tyus +	24	2005	-
	7		30. Name and address of person who	, ,	3a) (Type, Prir	nt)			9		×	
			31. Date filed (Month, Day, Year)	Chan 32. Registrar's Signature	'A							
	Sta Registi		AUG 3 0 2005	32. Registrar's Signature	Specte	•						

Doveen Price

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 205Certificate of Death 's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City Town, or Location of Death me (If not institution, give street and number **Examiner Funeral** Months Hours Director Usual Residence of Decedent Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code ō or items 23a Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 ☐ Marr 2 2100 Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Office kind of work done during most of working file. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic avant dary (0-12) College (1-4or 5+) 17. Father 's Name (First, Middle er's Name (First, Middle, Maiden /Relationshi 19b. Mailing Address Disposition urial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign the of Fund Al Service Lice. Egiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician K SOPHAGEAL 3 MONTHS /Medical Examiner NEMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 🗍 Unknown page 2 should Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 🗆 Yes 1 Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 1 ☐ Yes 2 No c 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier f Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

M

Registrar

31. Date filed (Month, Day, Year)

SISIVASALUAM

29b. Signature and title of certifier

(Check only one)

AUG 3 0 2005

wonallam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philadelphia road 32 egistrar's Signature

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DA5530

29d. Date signed (Month, Day, Year)

08-29-2005

suite 208, ND 2123

Amend Item 2 tate of Maryland (1893) (1993) (1994) Health and Mental Hygien 2 0 0 5 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Ronald F. Rowe August 22. 2005 11:00p. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 218 01d Riverside Road Baltimore Anne Arundel. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X**M 2□F Yrs 62 April 24,1943 **Director** 219 40 7150 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exactiner must be notified at 1 ☐ Yes 2 No Directo **Baltimore** Anne Arunde1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Riverside 23a 218 01dRoad 21225 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural', or Itams 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Anne Arundel Dept College (1-4or 5+) Elementary/Secondary (0-12) Draftsman of Public Works 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fil ment of Health and Mental H tant: If itam 27 Is markad ott Frank Hansford Rowe Evelyn Virginia Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna Copp/ Daughter 218 Old Riverside Road, Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Land 1 Land 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department o Important: If any injury or Glen Haven Mem. Park 08/27/2005 Glen Burnie, MD 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Donna Znamirowski per DVR 4001 Ritchie Highway, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine certificate be executed burial-transit COPD that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Bipolar Disorder use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Tes 2XNo Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🙀 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D17737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rastogi, M.D., 7575 Ritchie Hwy., Glen Burnie, MD 21061 32. Registrar's Signature 31. Date filed (Month, Day, Year AUG 3 0 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28333 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 08-27-2005 Year **ESTHER** 7:00 A-M MAE RICH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE 3412 DENNLYN ROAD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F Months Director 89 Yrs. 248-28-6975 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23e or 28e-f show other treumatic event, the Medical Examiner must be notified at Director 1 TYes 2 □ No BALTIMORE MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 3412 DENNLYN RD 21215 death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2X No Specify: 3√Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWORK 1117. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEOLA COCKFIELD WILLIAM FLEMING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3412 DENNLYN RD., BALTO., MD 21215 BETTYE SCOTT/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: If any Injury or once. ARBUTUS MEM. PK 09/01/05 BALTIMORE, MD \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee Tames 1 LAURENS ST., BALTO., MD 21217 1701 23a. Ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐ Unknown ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? el or Attending P s after death. I Director: After t 28b. Time of Certification: Natural Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospitel o within 24 hours aff To the Funerel Di completely filled in

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

5601 Loch 31. Date filed (Month, Day, Year) AUG 3 0 2005

29b. Signature and title of certifier

29a. Certifier

Medical

State

Registrar

BlVd 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven

29d. Date signed (Month, Day, (Year))
NUSES 30 (4 2005)

			For State Registrar	State of M	laryland / D	epartment of Certificate o	Health and f Death	Mental Hy	giene 2005	28334
	Physici /Medic		Decedent's Name (First, Middle,     Janice	Last)	Rod	gers		2. Date of De Month	25 <sup>Day</sup> 2005	3. Time of Death 6:15a M
	Examin		4a. Facility Name (If not institution,		)	4b. City, Town	, or Location of Deat	h	4c. County of De	
			Gilchrist N.H.		a da um last hint		WSON ar If Under 24 Hrs	8. Date of Bir	Baltim	
8	- Funeral Director		246-72 <b>-</b> 8414	7. A(1	ge (In yrs. last birt	Yrs. Months Day		(Month, Da	9. 8 3–46	irthplace (State or Foreign Country) N.C.
X	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
3	death with the Maryland ms 23a or 28a-f ehow	to	Md.	NA		Baltimore	<u> </u>			1 XYes 2 No
i	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
51	th with	aiD	5719 Denwood	Avenue		2]	L206		USA	
25-05 C 6:15 AM	after or its	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	If Yes, Give	?	13. Was Decedent of If Yes, specify C		Specify Yes or No to Rican, etc.)	14. Race - Ar Black, Wi Specify:	
%-3 5-0036	72 hours after "naturet", or ite	ted b	3 Widowed 4 Divorced  15. Decedent's (Specify only highest	Year or Dates:	16a.	Decedent's Usual Occ	unation	rkina	16b. Kind of Busines	Black
2121	_ 4 30	Completed	Elementary/Secondary (0-12)  12th grade	College (1-4or		(Give kind of work dor life. DO NOT use reti Service Re			Verizon	
	at Hyg	Bec	17. Father's Name (First, Middle, La	est)			18. Mother's Nar	me (First, Middle	, Maiden Sumame)	
aryland	Menta Menta arked	To	Marcellus		Wilks	5	Sı	ıdie	P	arker
3 ≥	s 1 and 2 should be filed within 72 he Health and Mental Hygiene. Item 27 le marked other than "natur other traumatic event, the Medical		James E. Rodg		sband 5	719 Denwo			er, City or Town, State imore, Md.	
Rock	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 le marked other than any injury or other traumatic event, It a Misonce.		20a. Method of Disposition  1 🕅 Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		cemeter	Disposition (Name of y, crematory or other p Mem. Par		Date 60-05	20c. Location - City of Randal	or Town, State Istown, Md.
A Balti	permit. Departmitmporta any inju		21. Signature of Funeral Service Li	censee	man	22. Name and Add	ress of Facility		more, Md. E. North	21202 Ave.
1			23a. Part1. Enter the disease, or c shock, or heart failure. List or	on lications that cause nly one cause on each I	d the death. Do n	ot enter the mode of d	ying, such as cardiad			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a Pc	lmon		ords, s			Onset and Death
	Examiner			Due to (or as	a consequence of	1	1			years
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of					1
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence o	<b>√</b> \.				
68760,	ficate be executed physician and s the burial-transit	edicai E		d		.,,				
	ertifica ding pt	Med	IF FEMALE:	22a If year autoom	of 2000000					
Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death certii ir death. ector: Affer this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy		23d. Date of d Month	elivery Day Year
ds, P	uires that signed by Id be deta	by	Part II. Other significant condition	s contributing to death t	out not resulting in	the underlying cause	given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Secor	The law requir sate has been si page 2 should	Completed						24a. Was	osy prior to	autopsy findings available completion of cause of
a E	itcien: Th certificate rector, pag		05 Was and a start of the	-				1 Yes		s 2 No
Κ	ystcien: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Out	27 204	Nat	ath (Check only o		with one
on of	ding Phys h. After this funeral di	lon; To	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. T	ime of 28c. In			dence 6 X ther (Sp how injury occurred	ecity)
ivisi	l or Attendi after death. Director: A in by the fu	Certification;	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place of In	jury - At home, far tc. <i>(Specify)</i>	m, street, factory, office		28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
۵	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	cal Ce	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best taminer: On the basis of	ot my knowledge,	, death occurred at the	time, date and place	and due to the	cause(s) and manner	as stated.
	the H thin 24 the F implete	Medical	one)  29b. Signature and title of centifier	and manner st	ated.		nse number		29d. Date signed (Mor	
	± ≱ ∓ 8		1 Al thr	they le	lyin	no Di	25205		1	25,2025
<i>1</i>	10		W.A. R.1	ro comply ed cause of a	2	) A. C	lines.	St. Ba	lto md	2120>
	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 0	2005 32 Regist	rar's Signature	Cooks				

				. For	State of Marylar			of Health and	•	-	28335
		A A		For State Registrar	-43	Cer	tificate	of Death		g. No.	
		ysicia		1. Decedent's Name (First, Middle, La:	RAYIN	7N			2. Date of Deat	Day Year	3. Time of Death
		Medic kamin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Tov	vn, or Location of Dea	th	4c. County of Dea	
		*	à- <b>.</b>	Franklin Squa		Center		sedale		Balti	more
		neral ector		5. Social Security Number 6. S	iex 11. Age (In yrs.		If Under 1 Y Months D	ear If Under 24 Hr ays Hours Min	8. Date of Birth (Month, Day, April 2	<sup>Year)</sup> 9,1941 Ma	thplace (State or Foreign ountry) rvland
	put			Usual Residence of Decedent  10a. State 10b. County	100 0	ity, Town or Loc	ation			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits
	11215-0036 within 72 hours after death with the Maryland ene.	be notified at	to	MD Balt			lle R	iver			1 Yes 2 XNo
	ith the	Borrott M	Olrec	10e. Street and Number			10f. Zip Co		10	g. Citizen of What C	ountry?
	sath w	TRAIL P	Funeral Director	4 Perch Court	10 146- 0	10.14		220		USA	
	after deal			11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No	łf		of Hispanic Origin? () Cuban, Mexican, Pue	to Rican, etc.)	14. Race - Ame Black, Whi	
, 3	215-0036 thin 72 hours at e.	LEXE	d by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			No Specify:		Specify: W	hite
re	15-115-110 T2 I	declice	plete	15. Decedent's Ed (Specify only highest gra	ide completed)	16a. Decede (Give k life. D	ent's Usual O ind of work d O NOT use re	ccupation one during most of wo stired)	rking	6b. Kind of Business	- '
nd	N POP	event, the Medical	Completed	Elementary/Secondary (0-12) 6th	College (1-4or 5+)	Lumb	er Ya	rd Worke	r	P.T.O'Ma	lley
J		* * * * * * * * * * * * * * * * * * *	Be	17. Father's Name (First, Middle, Last)  Andrew L. Ray					me (First, Middle, N	faiden Sumame)	
~	Though Man	traumatic	2	19a. Informant's Name/Relationship (		19b. Mailing	Address (St	Mae C		City or Town, State,	Zip Code)
Z	27 E 52	No. 1		Nancy Krystki		4 P	erch	Court Ba		MD 21220	
ج	2 8 2		1	20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐	Removal from State	Place of Dispos cemetery, crem YV1ewC	ition (Name of atory or other remat	place)		Oc. Location - City or Baltimore	
30	Baltimo	Injury B.	1	4 □ Donation 5 □ Other (Specify 21. Signatur) of Funeral Service Licen	"		N		_		
Š	Pariti	any l		K. Tern	Comell	M	300 N	Mace Ave.	Baltim	FuneralHore MD 2	omeofEssex 1221
	1.00			23a. Part1. Enter the disease, or com shock, or heart failure. List only	dications that caused the deal	th. o not ente	r the mode of	dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between Osset and Death
	Physic /Med			Immediate Cause (Final disease or condition resulting in death)	a. CARDIOM	YOPA	IMI				MONTHS
	Exam			Sequentially list conditions	CORONI	Ry A	RTO	RY DI:	SEASE		YEARS
	Pe	ısıt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					
	760, te be executed ysicien and	burial-transit	Exar	that initiated events resulting in death) Last	C. Due to (or as a consec	quence of):					
	- B - S	. 29	lcal	•	d						
	Box 68 eath certifica	for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	ikon
	O. B. he death the atte	ed for	siciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of c		ctopic pregn Other (s <i>pecif</i> )			Month	Day Year
	P.O. that the de	detached	Phy	9 □ Unknown  Part II. Other significant conditions c		sulting in the unc	larhinn cauc	a gryon in Part t	23e Did tob	acco use contribute to	the sauce of death?
	Division of Vital Records, or attending Physicien: The law requires that death.  Director: After this certificate has been signed.					yanting in the diffe		given act acts.		3 2 □ No 3 □ Pr	
	Reco e law rec	2 should	Completed						24a. Was an	24b. Were au	itopsy findings available completion of cause of
	The	bage :							perform	ed? death?	2□ No
	Vital F sicien: Th certificete		o Be	25. Was case referred to medical examiner? 1. ✓ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☑	/	•□	Other	ath Check only one		
	On of ding Phys		n: To	27. Mann of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA 28c.	njury at Work?	28d. Describe how	nce 6 Other (Spervinjury occurred	ify)
	VITE AND IT DE CTOT: AF	the	catlc	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2 No			
	Divisic	d in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stree fy)	et, factory, off	ice	28f. Location (Street) City or Town,	eet and Number or Ru State)	ıral Route Number,
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph	completely filled in by	edical C	Oneck only 2 Medical Exait	ysician: To the best of my kno niner: On the basis of examina	owledge, death	occurred at the	e time, date and place	a, and due to the car	use(s) and manner as	stated.
	To the P within 24	этрівіс	Med	one) 29b. Signature and title of certifier	and manner stated.			ense number		d. Date signed (Monta	
	F 3 F	5		Detwen 1	/asm		0.	17347		Aug 30	.220
	100		1	Name and address of person who	completed cause of death (Iter	n 23a) (Type, P	rint)		DUC.	RUSS	(0 . 0 - 1-2
	W.	Stat	e	31. Date filed (Month, Day, Year)	32. R a trar's Signa	U F O	MMI	1 3940-1	- DIIA	Daltin	01 F WN 2/33
	Re	gistra		AUG 3 0 2	2005	KA	Carlo.				

DHMH 17 Rev 1/2001

ORIGINAL

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

H	Physici /Medic		1. Decedent's Name (First, Middle, Last DERALD	BRUCE	REYN	OLDS,	SR.	2. Date of Dea Month AUGUS	th Day 27	3. Time of Death 2, 2009 10:57A
	Examin		4a. Facility Name (If not institution, give	n Hospita	11	Bal-	or Location of Deal			nty of Death
	Funeral Director		5. Social Security Number  212 · U0 · S+95  Usual Residence of Decedent	ex/	In yrs. last birthda Yrs.	Months Days			1954	9. Birthplace (State or Fore MARY LAND
death with the Maryland	Ba-f show	ctor	10a. State 10b. County	1	Oc. City, Jown or BAL	Location HMORE				10d. Inside City Limi
ith with th	23a or 21 ust be no	Funeral Director	10e. Street and Number 4010 ELSRUD	E AVE.		10f. Zip Code	2121	4	10g. Citizen o $\mathcal{U}$	of What Country?
<b>5-0036</b> 72 hours after deg	at', or Items Examiner m	by	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	er in U.S. 1:	3. Was Decedent of If Yes, specify Out 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	14. R B	ace - American Indian, lack, White, etc. city: BLACK
<b>21215-0</b> d within 72 ho	be tiled within 72 Ital Hygiene. Id other than "nate	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		16a. De (Gi life	cedent's Usual Occu ve kind of work done DO NOT use retire	during most of wo	rking	,	Business/Industry
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) CHARLES H.	REYNOLDS		jetoginjet	7	me (First, Middle,	Maiden Sum	
- 5	nt of Health and Menta If Item 27 is marked or other traumatic ev		19a. Informant's Name/Relationship (I DAKIA II · REYNOLDS	ype, Print) BAKKSONLE	19b. Ma	illing Address (Stree	t and Number or Ri			n, State, Zip Code) C 27609
Baltimore	rtmer rtant: njury		20a. Method of Disposition  1 We Burial 2 Cremation 3 Communication 5 Other (Specify Communication 5 Communication 1) Section 10 Leading 10 Lea	Removal from State	20b. Place of Dis cemetery, c KING M	position (Name of rematory or other pla	KK   8.3	0.05	BACTIM	n - City or Town, State  MAKY(AND)  NE FINERAL HIM
Be m	Depa Impo any i		21. Signature of Funeral Service Licen	+		22. Name and Addr 1905 YOR	K ROAD	BAUTIMOR	E, MAR	CYLAND 21212
	ysician Medical		23a. Part F. Enter the disease, or compands, or compands and the compands of t	one cause on each line. aAsysto	e death. Do not e	enter the mode of dy	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	attending physician and for use as the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. One to for as a c	consequence of):	Infar	ction			
. Box	the attending phy ched for use as th	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Uhknown} \)	23c. If yes, outcome of particles of the second of the se	Fetal death	B Ectopic pregnanc	у			Date of delivery Month Day Year
that	been signed by the atter should be detached for	ed by Physi	Part II. Other significant conditions co	ontributing to death but n	not resulting in the	underlying cause gr	ven in Part I.		bacco use co	ontribute to the cause of death?
I Rec	s certificate has bev lirector, page 2 sho	Completed						24a. Was a autops perform	sy	b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
of Vital Physician: T	iis certifi director	To Be	25. Was case referred to medical examiner?  1 Tyes 2 100	Hospital: 1 ☐ Inpatient	2 KER/Outpat	ient 3 DOA	200	ath <i>(Check only on</i> fome 5 ☐ Reside		other (Specify)
<b>⊆</b> 8	eath. .or: After this c the funeral dir	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			, M 1		28d. Describe ho		
DIVI	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certifi	4 Homicide determined	building, etc. (	Specify)			City or Town	n, State)	nber or Rural Route Number,
To the Hospital	e Fune	Medicai	29a. Certifier 15 Certifying Ph. (Check only one) 2 Medical Example 15 Certifying Ph. 2 Medical Example 16 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 17 Certifying Ph. 2 Medical Example 18 Certifying Ph. 2 Medical Exampl	ysician: To the best of n liner: On the basis of ex and manner stated	camination and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occu	e, and due to the caured at the time, d	ause(s) and r ate and place	manner as stated. a, and due to the cause(s)
To th	To th comp	Me	29b. Signature and title of certifer			29c. Licen:		2	9d. Date sign	ned (Month, Day, Year)
	in		30. Name a address of rson who o	completed cause of deat	h (Item 23a) (Tvn	D 4	6356	1	4UGU	MD 21239
	10		KNUSYOW TABO	1991, MD	5601 L	och Rav	en Biva	Baltie	nore	MD 21239
₽ .	Sta Registr	- 71	31. Date filed (Month, Day, Year) AUG 3 0 2005	32. Registrar's	olgnature (	E)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygien 2005

2. Date of Death

28336

3. Time of Death

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment o	of Health of Death	and Me		ien <b>2</b> 0 (	)5	28337
ı	Physicia	an	1. Decedent's Name (First, Middle, Las Ellen M. Rut	•				2	. Date of Deatl Month	Day	Year	3. Time of Death
	/Medic	al	Ellen M. Rut	herford	-)	4h City Tow	m, or Location		UGUST	4c. County	005	1:20 PM
	Examin	er	Union Memorial		,		ltimor			4c. County	N/A	1
	Funeral		Social Security Number 6. S	9x 7. A	ge (In yrs. last birthday		ear If Under		Date of Birth (Month, Day,	Year)		ace (State or Foreign
	Director		213-20-9913	☐ M 2 X X X	76 Yrs.	INOTALIS DE	ays Hours	J	une 25	1929	Mary	Land
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					1	0d. Inside City Limits
	Many I eh	tor	Maryland N/A		Balti	more						XXYes 2□No
	th the	irec	10e. Street and Number			10f. Zip Coo	de		10	g. Citizen of V	Vhat Coun	try?
	ath wi	rai	3939 Roland Avenu	e Apt 410		212				USA		
	er der Items	nne	11. Marital Status	12. Was Decedent Armed Forces 1 □ Yes 212	t Ever in U.S. 13.	Was Decedent If Yes, specify (	of Hispanic Or Cuban, Mexica	rigin? (Specif n, Puerto Ric	y Yes or No- can, etc.)		e - Americ k, White,	
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married  ***Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XIX	No Specify:	:		Specify	· Whi	.te
20	filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or Items 23a or 28e-1 ehow ant, the Medical Examinar must be notified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad		16a. Dec	edent's Usual Oc	ccupation	st of working	1	16b. Kind of Bu	ısiness/Inc	lustry
2	vithin ne. hen "	mple	Elementary/Secondary (0-12)	College (1-4or	5+) Mana	e kind of work do DO NOT use re ger of	<sub>tirod)</sub> Receivi	ing	T.	) _ 1. T) ·		
2	filed v Hygie ther t nt, In	CO	12 17. Father's Name (First, Middle, Last)			Departm	ent		First, Middle, N	Book Bi		
lan	id be ental ked o	To Be	William Howard	Gardner				ssie	,,		,	man
ary	shou and M s mar	-	19a. Informant's Name/Relationship (7 Howard E. Rutherf	ype, Print)		ing Address (Str	reet and Numb	er or Rural F			State, Zip	Code)
Σ,	is 1 and 2 of Health a Item 27 is other tree		noward E. Kutheri	ord Son		08 Kesw			-			
lore	ges 1 t of H if Iten or oth		20a. Method of Disposition 1 ☼ ¥ urial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	matory or other	place)	Date		Oc. Location -		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e-1 ehow any injury or other treumatic event, the Modical Examiner must be notified at once.		' 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen.		Loudon P				2005 B	altimo	re, M	aryland
Ba	Department of the position of		1 Jum B.	Hens	2	Burgee-I 3631 Fa	Henss-S 11s Roa	eitz H d, Bal	uneral timore	Home, Mary	Inc. Land	21211
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each	ed the death. Do not er	iter the mode of	dying, such as	cardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a LOWE	R GASTI	COINTE	STINF	AL E	BLEET	SING	(	2 HOURS
	Examiner			PICHT	s a consequence of):	2	EFFU	SION	1			12 HOURS
	p =	ner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequence of):				1			1100113
/	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or re	s a consequence of):						_	
8760,	icate be executed physician and s the burial-transit		,	. Due to (or as	s a consequence of).							
687	ificate g phys	edic		d.								
Вох	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Medical	230. was decedent pregnant	23c. If yes, outcome		⊒Ectopic pregna	ancy				e of delive	•
	e dea the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Other (specify				Moi	nth	Day Year
P.O.	law requires that the de as been signed by the a 2 should be detached f	Ph	Part II. Other significant conditions or	ontributing to death	but not resulting in the	underlying cause	e given in Part I	ı,	23e. Did tob	acco use conti	ibute to th	e cause of death?
Division of Vital Records,	quires n sign ald be	d by							1 🗌 Ye	s 2 No	3 🗌 Proba	abiy 4 Unknown
000	aw requires s been si 2 should I	Completed							24a. Was an	24b. V	Vere autop	sy findings available
R	0 L 0	mo							autopsy perform 1  Yes 2	ed?	leath?	pletion of cause of
/ita	sicien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					e of Death (C	Check only one	3		
of o	Physicien: r this certific ral director,	D.	1 Yes 2 No	Hospital:		ALL DOM		_	5 Resider			)
Ou	ding F h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ay Year) 28b. Time (		Injury at Work? 1 ☐ Yes 2 ☐		I. Describe how	w injury occurr	ad	
/ISI	Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At home, farm, s			1			er or Rural	Route Number,
Ö	s after el Direc ed in by	Certification;	4   nomicide	bullaing, e	etc. (Specify)				City or Town,	State)		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director; After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 15d Certifying Physics 2 Medical Example 15d Physics 15d P	ysician: To the bes iner: On the basis and manner s	t of my knowledge, dea of examination and/or i stated.	th occurred at the nvestigation, in n	ne time, date ar my opinion, dea	nd place, and ath occurred	due to the car at the time, da	use(s) and ma te and place, a	nner as sta and due to	ited. the cause(s)
	To the To the Comp	Š	29b. Signature and title of certifier	MD			cense number	0110		d. Date signed		
)			Jayr Zing				2438	746		-lug us	τ 2	7,2005
	le		JAYA SINGH 2		death (Item 23a) (Type		9RKWA	y Ro	Tuna	oc m	1 91	218-2895
	Sta	te	31 Date filed (Month Day Year)	32 Regist	trar's Signature		HWM	1 171	F C 07103	<u> </u>	الم مرا	-10 0012
	Registr	-	AUG 3 0 2	005 /	we do	had i						
					A 100 A	ALC: UNITED BY						

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 0 2005

Dorothy Seay, M.D. 10801 Lockwood Dr, Suite 205, Silver Spring, MD 20901

State of Maryland / Department of Health and Mental Hygien [] [] 5 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2005 Joan Alice Rohrbaugh 25 3:37 P August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 751 Sunnyfield Lane Brooklyn Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yes 2-24-1953 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min. 1 □ M 2 K F Yrs. Director 214-58-9835 52 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or Items 23a or 28e-f show the Medical Ezaminar must be notified at 1 ☐ Yes 2 No Director Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 751 Sunnyfield Lane 21225 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20XNo Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Financial Advisor Administrative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence Vogelsang Lillian Naomi Steinboch ٩ 19a. Informant's Name/Relationship (Type, Print) Husband 🍦 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mr. Ronald H. Rohrbaugh, Sr. 751 Sunnyfield Lane; Brooklyn, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State <u>~</u> ŏ permit. Page Department of Importent: If eny injury or once. \* 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 8-29-2005 Brooklyn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Ave S.W.; Glen Burnie, Maryland 21061 MO1357 Paneere 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician greenous Sins 13 disease or condition resulting in death) agressive 45 /Medical D to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE use . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No director, page 2: 2 🖪 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Hospital: P 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🎇 Residence 6 ☐ Other (Specify) the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred Certification; Injury at Work? After Division 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide filled within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10041422 26/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buthwere Lawel 20707 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 3 0 2005

			1 - For State Registrar  1. Decedent's Name (First, Middle, La			ertificate of I		2. Date of Death	g. No.	3. Time of Death
	Physicia /Medic		ALEXANDER H. F	RUSSELL V	<i>I</i> •			AUGUST	27 2005	6 6:45 AM
	Examin		4a. Facility Name (If not institution, giv 200 HOPKINS LA			4b. City, Town, or OWINGS	Location of Death	h	4c. County of De	
	Funeral Director		5. Social Security Number 6. S 217-09-3749	ex 7. Ag	ge (In yrs. last birthday 91 Yrs.	Months Days	If Under 24 Hrs. Hours Min.		9. B 1914 MAF	irthplace (State or Foreigr Country) RYLAND
S	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28e-f show or other treumatic event, the Modical Examilier must be multipled at	Funeral Director	Usual Residence of Decedent		10c. City, Town or I		7	10	g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 No Country?
	ours after deat	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ∰Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Mayes 2 ☐ If Yes, Give Year or Dates:	No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: WH	
	within 72 h ane. than "natu be Madica	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	(Giv life.	edent's Usual Occup e kind of work done o DO NOT use retired	during most of wor ()	rking	6b. Kind of Busines  MANUFAC	,
	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, Ite M.	To Be Co	17. Father's Name (First, Middle, Last, ALEXANDER H • F	)	- '	DOMNS		ne (First, Middle, Ma		TOKING
, Maryland	1 and 2 shou Health and M Iem 27 Is mar	_	19a. Informant's Name/Relationship (	**		ling Address (Street a			-	
Baltimore,	Part and		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specific			ematory or other plac			OC. Location - City o	MILLS, MD
Balti	permit. Departri Imports eny inju		21. Signature of Funeral Service Lice	Pare III		22. Name and Address IENRY W. 6924 YOI		S & SONS	S CO 2111	1.
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. MERKEI	d the death. Do not ea	nter the mode of dyin	g, such as cardiad	or respiratory arres		Approximate Interval Between Onset and Death ONE YEAR
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	b. RESPIRATORY ARREST  Due to (or as a consequence of):  RENAL FAILURE					5 MIN.
> '09/8	cate be executed obysician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as	a consequence of):					
O. Box 6	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
<b>D</b>	quires that in signed by uld be deta	þ	Part II. Dther significant conditions of	contributing to death t	out not resulting in the	underlying cause give	en in Part I.	23e. Did toba		to the cause of death?  Probably 4 Unknown
I Records,	aw Is b	Completed			NA SECULIAR SECULIAR			24a. Was an autopsy performe	ed?   death?	autopsy findings available completion of cause of s 2 \sum No
Vital	cien: ertific	Be	25. Was case referred to medical examiner?	11 2-1				ath (Check only one)	~	
of V	Physicien: this certific ral director,	ို	1 Yes 2 No	Hospital:			4   Nutsing n	lome 5 Residen		ecify)
Division o	te/	ertification:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	1	ury 28b. Time Ly Year) Injury	Worl	/ at <br Yes 2 □ No	28d. Describe how		
Divi	of or Attendir after death. I Director: Af d in by the fu	ertifi	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of in	jury - At home, farm, s lc. <i>(Specify)</i>	treet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,

Medical Certification; To Be Completed by Physician/Medical

within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physiciar completely filled in by the funeral director, page 2 should be detached for use as the buris

	IF FEMALE:
,	
	23b. Was decedent pregnant
	in the past 12 months?
	1 ☐ Yes 2 ☐ No
9 1	_

23c.	If yes, outcome of pregnancy
	1 Live birth 2 Fetal dea
	4 Pregnant at time of death
	o□11 to

egnancy Fetal death of death	3 Ectopic pregnance 5 Other (specify)

	23d. Date of delivery			
Ectopic pregnancy  Other (specify)		Month	Day	
		1		

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did
	1 🗆
	24a. Wa aut per
	1 VAS

24a. Was an autopsy	24b.	Were autopsy fir	ndings avail
1 □ Yes 2	No	3 Probably	4 Unkn
236. Did tobacco o	36 001	RIDULE TO THE CAU	ise of death

												1 Yes	2 N	o 1 Ye	s 2 No
25. Was cas		d to medical		26. Place of Death (Check only one)											
examiner 1  Yes		D	Hos	oital: 1 🔲 Inpatien	2 [	ER/Outpatient	3 🗆	DOA C	Other:	4 ☐ Nursing H	lome	5 Res	idence	6 ☐Other (Sp	ecify)
27. Manner o 1 X Natu 2 ☐ Acci	ral ident	5 Pending investigation	n	28a. Date of Injury (Month, Day	rear)	28b. Time of Injury	М	28c. In	iury at lork? Yes		28d.	Describe	how inju	ury occurred	
3 Suic		6 Could not b determined		28e. Place of Injur	y - At h	ome, farm, stree	t, fact	ory, offic	е		28f.	Location		nd Number or F	iural Route N

29a. Certifier (Check only one)	To the best of my knowledge, death occi 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, and due to the cause(s) and manner as stated. ation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

USLANE OUTHOS.

State Registrar 31. Date filed (Month, Day, Year) AUG 3 0



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2005

			1 - State Registrar  1. Decedent's Name (First, Middle, Last)	State of Marylan	d / Depa			Mental Hygi	g. No.	28341
	Physici	an .	1. Decedent's Name (First, Middle, Last)	Naomi Thel	ma Rev	nolds		Month	Day Year	7:05 A <sup>M</sup>
	/Medic	-	4a. Facility Name (If not institution, give st.		107		or Location of Deat	August	27, 2005 4c. County of Dea	
	Examin	er	Genesis Heritage		e ctr.	,	ndalk		Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 213-05-5495	7. Age (In yrs. 87	last birthday) Yrs.		r If Under 24 Hrs.		9. Bii (2) 7918 Ma	thplace <i>(State or Foreign</i> ountry) ryland
	and ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f show	tor	Maryland Balti	more			Dundal	k		1 ☐ Yes 2X No
	th the	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	23a (23a)		3468 Loganview D	rive			21222		United St	
O	after or ite	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever in U Armed Forces?</li> <li>1</li></ol>		Was Decedent of If Yes, specify Cul 1☐ Yes 2XNo	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
20-0	2 hou	ted	15. Decedent's Educa	ation	16a. Dece	dent's Usual Occu	pation	11	6b. Kind of Business	
7	within 72 hours ene. than "natural", he Medical Exa	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	e during most of wo	rking		
V	filed wi Hygien sthar th	Con	9 Years		Ho	memaker	T -= 1. 1		Own Hom	<u> </u>
/land		Be	17. Father's Name (First, Middle, Last)					me <i>(First, Middle, M</i> ohanna Sa	,	
Ξ.	d 2 should by th and Menta 7 Is marked traumatic so	ဥ	Raymond Rau  19a, Informant's Name/Relationship (Typ	a Print)	19b Maili	na Address (Strae			City or Town, State,	Zin Code)
<u> </u>	12 s h ar 7 ls trau		Mrs. Linda Sauer	(Daughter)					, Marylan	
ā,	le de le de		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other pl	2001	Date 2	Oc. Location - City o	Town, State
Банттог	8 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☑ Other (Specify)				ery 8/30/	2005	Baltimore	, Maryland
	C 0 0 -= 0		21. Signature of Just al Service Licenses						undalk, I	nc.
ñ	Pen ded fun suny		Inst 17.	your hy				ndalk, Ma		1222
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deat cause on each line. CORONA	h. Do not en	A RITE	ring, such as cardia	c or respiratory arres	St.	Approximate Interval Between Onset and Death
,00/	Medical Medica	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consecutive to (or a))).	T/A ( juence of):	- <del>H</del> Y	PERT	ENSIO	N	25 TEARS
O. BOX 68	at the death certificate by the attending phys nached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of c	ıl death 3[	Ectopic pregnan Other (specify)	су		23d. Date of de Month	olivery Day Year
ras, r.	as tha	by	Part II. Other significant conditions cont	ributing to death but not res	sulting in the c	inderlying cause g	iven in Part I.	23e. Did toba		o the cause of death?
l Kecord	The ate h page	Completed						24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
VItal	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	-=-			26. Place of Dea	ath (Check only one	)	
0	Physician: r this certific ral director,	은	1 ☐ Yes 2 ☐ No		EP/Outpatie	nt 3L DOA			nce 6 ☐Other (Sp	ecify)
	Jing Afte fune	ation	27. Man of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of injury (Month, Day Year)	28b. Time o Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe hov	w injury occurred	
DIVISION	To tha Hospital or Attend within 24 hours after death To tha Funaral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory, office	9	28f. Location (Stre City or Town,	eet and Number or F State)	lural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physical Certifical Certifi	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, deal ation and/or in	h occurred at the ivestigation, in my	time, date and place opinion, death occu	e, and due to the cau urred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the comp	Σ	29b. Signature and title of certifier	-8k ms	>	29c. Licer	DI416	0 A	d. Date signed (Mon	1h, Day, Year) 9, 2005
6	7		30. Nama and persons of person who con	national and the department of the state of	17 292) (TXCO) LT IN	en10-A	RITCH	HIE HI	GHWA'	1.1
***	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	houts 5				

	Ph /N Ex	ysi Mec am
ecords, P.O. Box 68760, <	law requires that the death certificate be executed	as been signed by the attending physician and

		State	f Maryland / D	k Indelible Ink. Ensur Department of Health a			28342
		1 - State Registra Amend Item #5 per	FH G847 9	Pogrifisater of Death		g. No.	
Physic	ian	Decedent's Name (First, Middle, Last)     LEONA	M. RAIL	FV	2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal	4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of	AUGUST	36 2005 4c. County of Death	12 30 PM
Exami Funeral		and the same of th	10 SF 1 + Al 7. Age (In yrs. last birti	ROSEDAL	E	BALTIM	CRE lace (State or Foreign
Director		Usual Residence of Decedent	7.4	rs. Months Days Hours	4 Hrs. 8. Date of Birth (Month, Day, 01-26-1)	931 Coun MAI	RYLAND
e Marylan 8e-f show Ilffed at	ctor	MD. 10b. County BALTIMORE	10c. City, Town	PARKVILLE		1	0d. Inside City Limits 1 ☐ Yes 2 XXIo
ath with th	ral Director	10e. Street and Number 3404 GLENSIDE DRIVE		10f. Zip Code 21234	10	Og. Citizen of What Coun	•
Ind 21215-0036 be filed within 72 hours after deeth with the Maryland stall hygiene. In a land the standard of	by Funeral	Armed F	NO KIND	13. Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,  1 ☐ Yes ※♥ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Americ Black, White, Specify: W	
5-0 72 ho	eted	15. Decedent's Education (Specify only highest grade completed,	16a.	Decedent's Usual Occupation (Give kind of work done during most)	of working	16b. Kind of Business/Inc	lustry
21215-0036 ad within 72 hours aft giene ier then "natural", or t, the Medical Everni	Completed	Elementary/Secondary (0-12) College (	1-4or 5+)	hool BUS ATTENDA		BALTIMORE (	COUNTY
E da by	To Be	17. Father's Name (First, Middle, Last) LEO WOODWARD		18. Mother EDN	's Name (First, Middle, M A OLIPHAN	,	
5 5 6 5 7 5	10	19a. Informant's Name/Relationship (Type, Print)  MILTON W.RAILEY (HUSBA	ND) 34	Mailing Address (Street and Number 04 GLENSIDE DRIVE	, PARKVILLE		
TOTE, ages 1 ar ant of Hea it: If item;		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3 ☐ Removal from  4 ☐ Donation 5 ☐ Other (Specify)	State cemetery	Disposition (Name of y, crematory or other place)  ND MEMORIAL PK. 0		PARKVILLE "M/	
Baltimore, permit. Pages 1 a Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Sergice Licensee	(R.G.RUTH)	22. Name and Address of Facility RUCK TOWSON FUNE		1050 YOR	ROAD
Physician /Medical	100	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	caused the death. Do neach line.	ot enter the mode of dying, such as c	ardiac or respiratory arre		Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions	(or as a consequence of the cons				week
760, e be executed sician and e burial-transit	cal Examiner	if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to	(or as a consequence o	f):			
Records, P.O. Box 687 The law requires that the death certificate its has been signed by the attending priyst bage 2 should be detached for use as the I	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, ou 1 □ Live	tcome of pregnancy birth 2 Fetal death nant at time of death own	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
Cords, P		Part II. Other significant conditions contributing to a		the underlying cause given in Part I.		acco use contribute to the	
Il Records, The law requires t ate has been signe	Completed by	COPD			24a. Was an autopsy perform	prior to con ued? death?	psy findings available apletion of cause of
	0	ANEM A 25. Was case referred to medical		26 Place o	1 ☐ Yes 2	No 1 ☐ Yes	2 🗌 No
	To B	examiner? 1 ☐ Yes 2 No Hospital:	Inpatient 2□ER/Out		sing Home 5 Resider		)
T grant			of Injury 28b. T		28d. Describe how	w injury occurred	
Division al or Attending after death. I Director: Afte	Certification;	3 Suicide 6 Could not be determined 28e. Place build	of Injury - At home, far ing, etc. (Specify)	m, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura State)	Route Number,
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	(Check only 2 Medical Examiner: On the b	e best of my knowledge, asis of examination and ner stated.	death occurred at the time, date and for investigation, in my opinion, death	place, and due to the can occurred at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier		29c. License number		d. Date signed (Month, L	
		1 GMN8		NO0262	-96 8	-26-2	005
4		30. Name and a dress of person who completed cau  DR. JASON BRNBAUN  31. Date filed (Month, Day, Year)  32. E	se of death (Item 23a) ( 4 9000 FRI Registrar's Signature	Type, Print) INKlin SquareD	TIVE, BALT	MORE, MD 2	1237
St Regist	ate rar	AUG 3 0 2005	logues H	Costo			

Darrell M. Stanley NK 05-5170 KG

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

51/0			riease	Type of Pili								20212
		1 - Stata		State of Ma	aryland	/ Depa	rtment o	f Health and of Death	d Mental Hy		.005	28343
		Registrar	e (First, Middle, La	ct)			inicate	or Death	2. Date of D	Reg. No.		3. Time of Death
Physici	ian				n 1 1.	- l		Chanlass	Month	Day	Yeer	
/Medi		Darrell		Mark e street and number)	AIK	bear		Stanley  n, or Location of De	July 3		Ounty of Death	7:20 P M
Examir	ner		•						adri	40.0	ounty or Death	
- AM		5. Social Security N	dgehampto		pt. A le (In yrs. las	t hirthdayl	Balt If Under 1 Y	imore Bar   If Under 24 F	drs   P. Data of B	ieth	O Ridb	alone (State or Sourier
Funeral				M 2□F	45	Yrs.	Months Da		in. (Month, D	ау, Year) 3 59	Cou	ptace (State or Foreign ntry)
Director		093-54-7 Usual Residence of							08 0.	3 39	L	1Y
land w		10a. Slate	10b. County	***	10c. City,	Town or Loc	ation					10d. Inside City Limits
Mary	ō	MD	NT A		Do 1	ltimo	100					1 XYes 2 No
with the Maryland a or 28a-f show	Director	MD 10e, Street and Nu	MA NA		Da.	LCIMO	10f. Zip Co	ie		10g. Citize	n of What Cou	niry?
death with the Maryland me 23a or 28a-f show								2222			II C 3	,
er death w Items 23s	Funerai	5805 Gle	enkirk C	12. Was Decedent	Ever in U.S.	13. V		21239 of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or N		U.S.A.	
r Iter	F		ried 2 Married	Armed Forces?					Jerto Rican, etc.)		Black, White,	etc.
urs aff	by	3 🗆 Widowed		1 ☐ Yes XIX If Yes, Give Year or Dates:		1	☐ Yes 2🎇	No Specify:		S	pecify:	Black
natural',	ted		15. Decedent's E	ducation		16a. Deced	ent's Usual O	cupation		16b. Kind	of Business/Ir	ndustry
hin 7	pie	(Spec	cify only highest gra	College (1-4or	5+)	life. D	ina of work a O NOT use re	one during most of tired)	working			
d with	Completed	12th gr		2yrs		Se	lf Em	ployed		В	roker	
oud be filed within 72 hours after Mental Hygiene.  arked othar than "natural", or lie after event, the Medical Examina	Be	17. Father's Name	(First, Middle, Last,	)				18. Mother's I	Name (First, Middle	e, Maiden St	итате)	
Aenta Aenta rked tice	10	Harold	Stanley	Sr.				Ruth	Willis			
S D E E	-		lame/Relationship (			19b. Mailin	g Address (St	eet and Number or	Rural Route Numi	ber, City or 7	own, State, Zij	o Code)
permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra		Lisa Yo	oung-Fri	end		5805	Glen	kirk Ct	., Balt:	imore	, Md	21239
tem tem oth		20a. Method of Dis	position		20b. Plac	ce of Dispos	sition (Name of atory or other	place)	Date	20c. Loca	tion - City or T	own, State
Page ent c nt: If ry or			☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State				Park 8	/24/05	Dand	-11c+	own Md
orta	1		uneral Service Licer		KING	22.	Name and A	dress of Facility F/H West	24/05	Nand	direc.	JWII MG
Depa Impo any la		Kero	me A.	Shumper	NJ	e. 4	arch 300 W	r/H west abash A	c ve. Bali	timor	e, Md	21215
		23a. Part1. Enter t	the disease, or com	plications that cause	d the death.							Approximate
Dhusisian		Immediate Cause	(Finat	one cause on each li	ne.		0 >-	t wo	11180	)		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		a. Due to (or as	a sonseau	» CLIV	will.	1 200	move			
Examiner			- 1	Duo 10 (01 u 3	u <b>4</b> 01136446	11000).						
	ē	Sequentiatly list co if any, leading to in cause. Enter Unde Cause (Disease or	onditions, mmediate	b. Due to (or as	a conseque	nce of):						
insit	Examiner	cause Enter Under Cause (Disease or	erlying r injury									
be executed icien and burial-transit	×a	that initiated events resulting in death)	S	Due to (or as	a conseque	nce of):	-					
ate be executed sysicien and he burial-transit	cai											
icate phys s the				d								
leath certificate t attending physic	Physician/Med	IF FEMALE: 23b. Was deceden	at eregeent	23c. If yes, oulcome	of pregnance	у				230	d. Dale of deliv	env
atte	ciai	in the past 12	2 months?	1□Live birth 4□Pregnant a			Ectopic pregn Other (specif				Month	Day Year
at the de by the a	ıysi	1 ☐ Yes 2! 9 ☐ Unknown		9□ Unknown				,				
g 8 €		Part II. Other signi	ificant conditions	contributing to death b	out not result	ing in the un	derlying caus	given in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
uires sign Id be	d by								1 🗆	Yes 2	No 3 Pro	bably 4 Unknown
v requir been si should	Completed								24a. Wa		Odb Wass sub-	ann findings are take
e lav	d L								auto	opsy formed?	prior to co	opsy findings available empletion of cause of
									1 Yes	2□No	Yes	2□ No
ysician: The is certificate hadirector, page	Be	25. Was case reference examiner?		Hospital:				Other	Death (Check only			
Phys this	2	1 X es 2 ☐ 27. Manner of Deat		1 Inpati		R/Outpatient 8b. Time of		4 🗆 Nursin				wat scene
ding Alter After funer	io.	1 🗆 Natural	5 Pending	28a. Date of Inju	y Year)	laiury	D.M.	njury at Work? 1 ∐ Yes 2 🙀 No	De Coo	- 1	shot	
tten death tor:	ical	2 ☐ Accident 3 ☐ Suicide	investigatio	09 Place of In		app 16					•	al Pouta Number
or A after Direct in by	Certification:	4 Homicide	determined	28e. Place of In building, et	c. (Specify)		or, ractory, or		City or To	own, State)	2422 13	al Route Number,
pital ours a eral (		29a Carrior	1 Cartifular D	hydiaina T- th- b		me		- 4	Hampton	Drive	Apt A	Salto.MD
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)	2 NMedical Exa	hysician: To the best minar: On the basis of	f examinatio	eage, death on and/or inv	occurred at the estigation, in i	e time, date and pl ny opinion, death o	ace, and dule to the ccurred at the time	e cause(s) ar , date and p	nd manner as s lace, and due t	stated. o the cause(s)
thin the imple	29b. Signature and the of certifier									29d. Date signed (Month, Dey, Year)		
7 × 1 0			HOW	$\sim ///$								
			VI	() , ,			Ο.	C.M.E.		Augus1	t 1, 20	UD

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 0 2005

32. Regislrar's Signature freels

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S - 72 . HOEAN 1111 111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 2005

28344

	1	For State Registrar		Ce	rtificate of	Death	FI FI	leg. No.	0.0	20044
		1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	th Day	Year	3. Time of Death
Physicia /Medica		Gladys		May	Suc	lial	Aua		05	10:10 PM
Examine		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Death	J	4c. County	of Death	
		Levindale Nurs	ing Home		Baltim	nore				
uneral		,		e (In yrs. last birthday,	Months Days		8. Date of Birth (Month, Day	Year)	9. Birthpli Count	ace (State or Foreign
Director		220-11-9705	10M 20F	81 Yrs.	I Violitis Days	110013	07 01			maica
>	⊢	Usual Residence of Decedent		100 City Town and					144	No. 1 - ide City t in its
=		10a. State 10b. County		10c. City, Town or L					10	od. Inside City Limits 1 X Yes 2 No
s marked other than naturel, or liens 23s of 25s-1 show number count be nutitied at	2	MD NA		Baltimo						
DU S	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of V	Nhat Count	ry?
Tan I		6905 Reisterst	own Road		2	21215		U,	S.A.	•
	runeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac	e - America ck, White, e	
9		1 Never Married 2 Married			1 ☐ Yes 2X No			Specify		
	0 b	3 XWidowed 4 ☐ Divorced	Year or Dates:					0,000.1	Asi	an
	Сотріете	15. Decedent's (Specify only highest of	Education trade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done	pation during most of work ed)	ing	16b. Kind of Bu	usiness/Ind	ustry
	ᄐ	Elementary/Secondary (0-12)	College (1-4or	D+)	Housev			Н	ome	
		8th grade	na		Housev					
90	ă	17. Father's Name (First, Middle, La				18. Mother's Nam			10)	
F	_	Harry Mitchell				Vancit	<u>_</u>			
		19a. Informant's Name/Relationship	(Type, Print)		-	t and Number or Rur				· ·
		Cynthia Johnso	on-Daught			erstown	-			
once.	1	20a. Method of Disposition 1 X Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	osition (Name of Imatory or other pla	100)		20c. Location -		
		`4 □Donation 5 □ Other (Spec		Dove	cot	9/3	/05	Kings	ton,	Jamaica
9		21. Signature of Funeral Servica Lic	ensiee		2. Name and Addre					
8		Dum	Stea	Co M	arch F/E	ash Ave,	Baltin	nore.	БМ	21215
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
ian	d	Immediate Cause (Final	Cha	i- Ola	to the	121	monar	1	200	Onset and Death
dical		disease or condition resulting in death)	a Due to (or as	a consequence of):	men	De Juli	1101120		ALC.	
ner				,			0	<b>5</b> 0.		
	i i	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):						
i	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
1	Exa	resulting in death) Last	Due to (or as	a consequence of):						
			d							
	Medical									
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Da	te of deliver	v
1	rnysician	in the past 12 months?	1∐Live birth 4∐Pregnant at		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	У				Day Year
1	2	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown							
		Part II. Other significant conditions	contributing to death b	ut not resulting in the u	undertying cause gr	ven in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
	d b						1 🗆 Y	es 2 No	3 🗌 Proba	bly 4 Unknown
3	Completed						24a. Was a	24h	Mara autan	ou findings overlable
	-						autops perfori	n 240. 1	prior to com death?	sy findings available ipletion of cause of
			,				1 ☐ Yes	2 <b>2</b> (Vo	1 ☐ Yes	2 No
Q	ן מ	25. Was case referred to medical examiner?	Hospital:			26. Place of Deat	h (Check only or	(9)		
-   1	2	1 ☐ Yes 2 No	Inpatie			THE RESERVE THE PARTY OF THE PA	me 5 Reside			)
	0	27. Manner of Death 1 Natural 5 ☐ Pending	28a. ate of Inju (Month, Da	y Year) 28b. Time o	Wo		28d. Describe ho	w injury occurr	ed	
1	Car	Accident investigati	he			Yes 2 No				
1	Certification:	4 Homicide determine		ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (Si City or Town		er or Rural	Route Number,
3	edical	(Check only	Physician: To the best aminer: On the basis o	of my knowledge, deat	th occurred at the ti	me, date and place,	and due to the cred at the time. d	ause(s) and ma	nner as sta	ited. the cause(s)
3		one)	and manner at	ried.						
-	Σ	29b. Signature and title of certifier	1//		29c. Licens	se number	2	9d. Date signed	J (Month, D	Pay, Year)
		Allegille	MIL		- V	1361		Hugy	5+2	5,2005
/		30 Name and address of person wh	o completed cause of d	leath (Item 23a) (Type	Print)	, ,	11.	01,		71 -
		Gora/Wes the	ne 10	2434	U. Bel	ludere i	We.	5a/tz	0,11	6225
State	е	31. Date filed (Month, Day, Year) AUG 3 0	2005 32. Registr	ar's Signature	Casto D					
tra	r	HUU 3 V	COOL CON	180 15° JE						

State of Maryland / Department of Health and Mental Hygiene 2005 28345 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Marguerite 25 2005 Samuels 9:58a. August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Nursing Home Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 □ M 2 🕱 F 86 Director 220-05-8214 10 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director XXYes 2 □ No MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5112 Norwood Ave Funeral 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 21215-0036 1 ☐ Yes 2 X No Specify: 3℃ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Ie marked other then ' Elementary/Secondary (0-12) Coilege (1-4or 5+) 12th grade Custodial Social Security Adm. Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) William Moody Amanha Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Item 27 le or other tra Paul Samuels-Son 3816 Janbrook Road, Randallstown, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If any injury or once. 8/31/05 Glen Burnie, Md Cedar Hill 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** end - Stan 1)emen 100 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto for as a consequence offburial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 menths? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, dise Ase 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Vital 1 ☐ Yes 2 X No in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 D No Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 within 24 hours e To the Funeral C completely filled i filled Hospital Contrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25 26.1 und who completed cause of death Jum 23a) (Type, Print) BMR . Registrar's Signature 31. Date filed (Month, Day, AUG 3 State 0 2005 Registrar

	1- For Amend Item Registrar	10State of Marketod &	egartment of Health and Certificate of Death	Mental Hygien	
Physiciar /Medica	$=$ $\omega$	PARIE SUEH	LA	2. Date of Death	3. Time of Death
Examine	4 5 10 44 27 11 15 11	ive street and number)	4b. City, Town, or Location of Dea		c.County of Death Baltimore
Funeral Director	5. Social Security Number  6.  20-12-8756  Usual Residence of Decedent	Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hr. Months Days Hours Min		9. Birthplace (State or Foreign Country)  MARYLAND
filed within 72 hours after death with the Maryland Hygiene. Wher than "neturel; or items 23e or 28e-f show ont, the Medical Examinational be coulding at	10a. State 10b. County	MORE 3HB	GARDEN AVI		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ifer death with the Mar ritems 23e or 28e-f si diref must be notified	3118 GARDEA	1 AUE	10f. Zip Code 21234	10g. C	itizen of What Country?
urs after des	3 → Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ NO If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puel  1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify:  WHITE
within 72 ho	15. Decedent's (Specify only highest g  Elementary/Secondary (0-12)	Education 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo		Kind of Business/Industry
2 should be filed with and Mental Hygiene. le marked other that eumetic event, then To Be Comm	17. Father's Name (First, Middle, Las	AN SR.	HOMEMAKER 18. Mother's Na MATH	me (First, Middle, Maide	ESIOENCE n Sumame) WERNEKE
ds branch and	19a Informant's Name/Relationship  KICK SUEHLA  20a. Method of Disposition	4 / SON (60 20b. Place of	Mailing Address (Street and Number or R  OP OTTER CLEE  Disposition (Name of business)	K RO. E	or Town, State, Zip Code)  06Ewood, MO 21040  Location - City or Town, State
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.	1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	ify) VET	ERANS CEMETERY  22. Name and Address of Pacility	LANS FUN	ERAL CHAPEL
Physician	shock, or heart failure. List onl Immediate Cause (Final disease or condition	mplications that caused the death. Do not yone cause on each line.  METASTATIC LL	ot enter the mode of dying, such as cardia		Approximate Interval Between Onset and Death 7 MONTHS
/Medical Examiner	resulting in death)	Due to (or as a consequence of HISTORY OF BR	REAST CANCER		7 MONTHS
ificate be executed  physicien and as the burial-transit		c.  Due to (or as a consequence of Due to (or as a consequence	, 		
ath certi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 X No 9  Unknown	23c. If yes, outcome of pregnancy 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
w requires that the de been signed by the a should be detached in the de the detached in the d	Part II, Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the cause of death?  No 3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Attending Physicien: The strength.  Togeth.  Togeth.  Togeth.  Togeth.  Attending Physicien: The incention of the funeral director, page.	examiner? 1 Yes 2 No		patient 3 DOA Other: 4 Nursing H	ath (Check only one)  Home 5 Residence  28d. Describe how inju	
To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Medical Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be an place of lainer As have for		28f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in Medical Cert		Physician: To the best of my knowledge, miner: On the basis of examination and and manner stated.	death occurred at the time, date and place Vor investigation, in my opinion, death occ	e, and due to the cause(s urred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
To the within To the compl		Ville	29c. License number	29d. Da	ate signed (Nonth, Day, Year)
10	30. Name and address of person who	o completed cause of death (Item 23a) (	D 30149  Type, Print)		
State	HECTOR R. SILV 31. Date filed (Month, Day, Year)	0 2005 Registrar's Signature	SLER DRIVE, TOWS	ON, MARYL	AND 21204
Registrar	ששער ט	U LUUS PARAGES S			

		•	1 - For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of H rtificate of I	lealth an Death	d Mental Hy	giene 0	05	28347
			1. Decedent's Name (First, Middle,	Last)				2. Date of Do	eath Day	Year	3. Time of Death
	Physici /Medic		Mary Louise Sand	dlin					19, 200		12:10 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	r Location of D	eath	4c. Coun	ty of Death	
			Charles County 1		h : h : h	La Plata	If Under 24	Hrs.   O. D	Char		land (Clark or Francisco
	Funeral			7. Age (In yrs. II. 1		Months Days		vlin. (Month, D	7, 1920	9. Birthp Cour Flo1	
	Director		266-07-7159 Usual Residence of Decedent	04	•			NOV. I	7, 1920	FIOI	Tua
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	e Mar	ctor	Maryland Charles	La P	lata						1 X Yes 2 □ No
	ift the or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	ath w		10200 La Plata 1			20646			United		
	er de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🛣 No	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0- 14. Ha	ace - Amendack, White,	
5	irs aft	by F	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Spec	ify: Wi	nite
ž	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or items 23a or 28a-f show ent, the Mudical Examinatio unit be molfilled at	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation	Town white a	16b. Kind of		
21215-0036	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most or d)	working			
	ed wil	Con	6		Facto	ory Worke					nufacturing
n D	d tal	Be	17. Father's Name (First, Middle, La	est)				Name (First, Middle	e, Maiden Suma	ime)	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Mardical Examinar mant be inclined at	P	Barney Bass 19a. Informant's Name/Relationship	(Time Reint)	10h Mailie	a Address /Street		riffis or Rural Route Numl	har City or Tour	n State 7in	(Cade)
Z Z	d 2 sl th an t7 is r traur		Raymond Elliott	Son				Waldorf,			, 0000)
ď	Health tem 27 iother tre		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	Ţ	Date	20c. Location		own, State
<u> </u>	Pages nent of ant: If it ury or o		1 ☐ Burial 2 MCremation 3  1 ☐ Donation 5 ☐ Other (Spe	Met	ropol: mator		I .	-21-05	Alexan	dria.	VΔ
altimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Li	TOLC		y 2. Name and Addre leptune Sc	ss of Facility		Alexan	ur ra,	V 21
ñ	Pe a m a	1 1	Jul. UE	Sall	3	4042 US 1	Hwy 19	North Pal	lm Harbo	or, FL	34684
		-/	23a. Part1. Enter the disease, or concept, or heart failure. List or	omplications that caused the death	. Do not ent	er the mode of dyin	ng, such as car	rdiac or respiratory	arrest,		Approximate Interval Between
100	Physician	1	Impediate dause (Final ease or condition	a Debility							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
	LAGITITIE	L.	Sequentially list conditions,	b	ienco of):						
	led nsit	nine	if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events	Due to (or as a consequ	derice ory.						
_,	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
58760,	cate be executed physicien and the burial-transit	dicai		d							
_		0									
Вох	eath certifi attending j	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		DEctopic pregnancy	,			ate of delive	ery Day Year
O. E.	at the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify)			14	TQTTUT	Day 16a
P.O.	The law requires that the death certif tit has been signed by the attending page 2 should be detached for use a		Part II. Other significent condition	s contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I	23e. Did	tobacco use co	ntribute to t	he cause of death?
Records,	signed to	d by	, arm emoragement			11001.) and 02000 giv	011111111111111111111111111111111111111		Yes 2□No		pably 4 XUnknown
Ö	w require been si	ete						24a. Wa	s an 24h	Were auto	psy findings available
Re	The lavate has	Completed						auto	opsy formed?	prior to co death?	mptetion of cause of
	ilcian: Th certificate rector, pag	Ö	25. Was case referred to medical				26 Place of	1 ☐ Yes  Death (Check only	21	1 🗌 Yes	2 No
>	ysicie s cert direct	To B	examiner? 1 ☐ Yes 2 🗓 No	Hospital:	ER/Outpatier	nt 3 DOA Oth	or	ng Home 5 Res		ther (Specif	(y)
0	Attending Physician: ar death. ector: Atter this certific by the funeral director.		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	y at	28d. Describe	how injury occu	urred	
000	endir eath. or: Af he fu	atic	2 ☐ Accident investiga	tion		M 1 1	Yes 2 □ No				
Division of Vital	or Att ter de irect n by t	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ome, farm, sti /)	reet, factory, office			(Street and Nun own, State)	nber or Rura	al Route Number,
	pital i ours a erai D	O	202 Cortifies 10 Constitution	Dhysician: To the heat of and the	udades des	h nonumed at the arr	mo data ========	lana and due to the	2 021120/2/ 227	200001	tated
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical		Physician: To the best of my kno xaminer: On the basis of examinal _and manner stated.							
	ithin o the omple	Med	29b. Signature and title of certifier	$\sim$		29c. Licens	a number		29d. Date sign	ed (Month,	Day, Year)
	- s - ō		1 Dames	Harring		000	529	, 9	7/2	9/0	5
	1		30. Name and address of person w	ho completed cause of dean (Item	1 23a) (Type,	Print)			1	/	- 12
V	2 '		James Harrin			1		aPlata, M	D 20646		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar Signa	ture 3.	frede	,				
	Regist	elf		CONTRACTOR	Waster Walter	11					

State of Maryland / Department of Health and Mental Hygien 2005 28348 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:00p2005 Aug 27, Carroll C Shores /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel 505 Marion Rd If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex **XX** M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min Yrs. ian 4, Director 214-18-3391 82 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10h Counts 10d. Inside City Limits 27 is marked other than "naturel", or itams 23a or 28e-f ahow traumatic event, it e Madical Examinations and by molified at 1 Yes 2 No Completed by Funeral Director Anne Arundel Glen Burnie 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code 21061 USA 505 Marion Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WR Grace & Co 10 Foreman 17. Father's Name (First, Middle, Last)

James C Shores 18. Mother's Name (First, Middle, Maiden Surname) **Ruth Naomi Moran** Be Pages 1 and 2 should be finent of Health and Mental Hint: If item 27 Is marked ot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Marion Rd Glen Burnie, MD Frances Shores 21061 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery Sept 1, 2005 Glen Burnie MD 6 any injury 22. Name and Address of Facility
Fink Funeral Home, P.A. e of Funeral Service Licen 21. Signard Gregory 426 Crain Hwy, Glen Burnie, MD 21061 Approximate Interval Between Onset and Death Enter the diveas mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly on-cause on each line. Immediate Cause (Final **Physician** cardina a u disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner 120 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Be Completed certificate has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Certification: To 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death unaral Diractor: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To tha Funaral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 7 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 2500 Cron 31. Date filed (Month, Day, Year) 32. Registrar Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200528349 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 25 15:01 SAVAGE AMOUST 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hookins timore Johns If Under 1 Year Birthplace (State or Foreign Country) yrs. last birthday) Date of Birth 5. Social Security Number **Funeral** Days 214-56-470 Months Hours 1 M 2 XF Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examt at must be rediffed at once. 1 XYes 2 □ No more Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 Xo Specify: Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 18. Mother's Name (First, Mid 17. Father's Name (First, Middle, Last) Be 10b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Dhn E 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses oac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician PRUDRESSIVE PALAUSU 4 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 month LIVERFAILURE Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed attending physician and for use as the burial-transit Inonta RENAL FATURE Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 pe 1 Yes 2 No 3 Probably 4 Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2[] No 2 No 1 Tyes Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No ٥ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 [] Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ZE5-000

State Registrar

AUG 3 0 2005

MANDIA J. WANDER

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien  $^2$  0 0 5 28350 1 - For Stata Registrar Certificate of Death Reg. No. 1. Deofident's Name (First, 2. Oate of Death 3. Time of Death **Physician** 24 2005 525 PM /Medical 4b. City, Town, of Location of Death **Examiner** If Under 1 Year If Under 24 Hrs. Funeral or Foreign Days 10M 20F Months Hours Min. Director 10c. City, Town or Location 10d. Inside City Limits 10a permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-1 show empty injury or other treumetic event, the Medical Examinist must be notified at once. 1 ☐ Yes 2 No Director 10f. Zip Coda 10g. Citizen of What Country? Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race -American Indian. Black, White, etc 1 Never Married 1 Yes 2 No If Yes, Give Year or Dates: 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use regired) 16b. Kind of Business/Indug Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle Maiden Sumame) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signarule of Funeral Service Lives 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): nerel Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner?
1 Xes 2 No Be 26. Place of Death (Check only one) , lih tan Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 2 Accider 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident within 24 hours after deat To the Funerel Director: Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar leted cause of death (Item 23a) (Type, Print)

MA.

UKINA

		4	For 1 - State Registrar	State of Mary	rland / Depa	artment of H	ealth and M	Mental Hyg	giena 0 0	5 2	8351
		200	Hegistrar     Decedent's Name (First, Middle, L			rimouto or E	Journ	2. Date of Dea	109. 110.		Time of Death
U.	Physici	an	_	R.		Stevanus	6	Month August	Day	Year	
	/Medic	_	Larry  4a. Facility Name (If not institution, g.			4b. City, Town, or	26, 2		2:35P <sup>M</sup>		
	Examin	er				,				101	
* %		<u>4</u>	601 Canal Lane 5. Social Security Number 6.		yrs. last birthday)	Annapo If Under 1 Year		Anne	Arund		
	Funeral Director		217–38–3890	1 <b>X</b> M 2□ F	65 Yrs.	Months Days	Hours Min.	2,1940	Country)	(State or Foreign	
			Usual Residence of Decedent	1		1	1	0 0210 21	7.5.0		
	/land		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. fr	nside City Limits
	Mar	tor	MD. Anne A	rundel	Annapo	olis				1	☐Yes 2XNo
	r 282	Irec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	h witi	Funeral Director	601 Canal Lane			21401			USA		
	deat	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race	- American In	ndian,
9	after or Ite	F	1 Never Married 2 Married			1 ☐ Yes 2 <b>X</b> No	Specify:	o riioan, oto.,	1	White	
ဗ္ဗ	ours	d by	3 Widowed 4 Divorced	Year or Dates:			opocny.				
5	within 72 hours after death with the Maryland ene. than "neturel", or items 23s or 28s-f show item "neturel", or item and be mullified at	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occupa kind of work done of	during most of wor	king	16b. Kind of Bus		•
2	Aithin han han	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	,		Nationa	l Secu	rity
2	tygiel her ti		12 years 17. Father's Name (First, Middle, Las	6 years	Exec	cutive Mar	nager 18. Mother's Nam	no (First Middle		ency	
anc	be fi	Be	Leroy Homer Stev					F. Smith		"	
Maryland 21215-0036	d Mer marke	P	19a. Informant's Name/Relationship		10h Maili	ng Address (Street a				State Zin Cod	(a)
Mai	12 st h and 7 is n traun		·			Canal Lane			-	siate, zip cool	6)
e,	1 and Healt em 2 ther		Barbara Stevanus  20a. Method of Disposition		20b. Place of Dispo		e, Amapo	Date	20c. Location - 0	Dity or Town. 5	State
٥	tiges if it		1X Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, cre	matory or other place Faith Cenet	Aug	ust 31,			
Baltimore,	t. Partmer rtant rtant njury		* 4 □ Donation 5 □ Other (Spec 21. Signature of A eral Service Lic	,/			- , 20		Rosedale		
Ba	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dr.p. irment of Health and Mental Hygiene. In portant: if item 27 is marked other than "natural", or items 23c or 28a-f show are yinjury or other traumatic event, it is Modical Exacting and the notified at the 2.		21. Signature of the eral service Lic	110/1	رِّ ا	2. Name and Address Connelly F 7110 Solle	Tuneral F	Iome Of I	Dundalk,	P.A.	1222
	4/.		23a. Part). Enter the disease, or co	mulications that caused the							proximate
k			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.	1 0000		9,000,100,001,010		Λ	Inter	erval Between set and Death
	Pnysician /Medical		disease or condition resulting in death)	a. WEN	4714	CIH	41410	COM	UKK	30`	YEAKS
В	Examiner			Due to (or as a co	onsequence of):					- 1.0	
		<u>-</u>	Sequentially list conditions,	b. Due to (or as a c	onsequence of):						
T	ted nsit	n in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,						
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
120	icate be ex physician s the buria	call		d							
68	ificati g phy as the										
Вох	death certificat e attending phy d for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		7			23d. Date	of delivery	
ă	that the death ned by the atter detached for t	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 [ 4□Pregnant at tim		⊒Ectopic pregnancy □ Othe <i>r (specify)</i>			Mon	th Day	Year
0	t the by the ache	hys	9 Unknown	9□ Unknown							
٣.	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions	s contributing to death but n	ot resulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the car	use of death?
ĕ	v require been sig should b							1 🗆 Y	es No	3 Probably	4 Unknown
00	aw requ s been 2 shoult	ompleted						24a. Was a	an 24b. W	/ere autopsy fi	findings available tion of cause of
æ	The law cate has b page 2 st	Eo						perfor	med? de	eath?	
Vital Records,		e C	25. Was case referred to medical				26. Place of Dea	ith (Check only or		- Y	
>		To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Othe	er: 4 🗌 Nursing H	ome 5 esid	lence 6 🗆 Othe	r (Specify)	
J of	ng Ph ter th		27. Manner of Death  Natural 5 Pending	28a. Date of Injury (Month, Day Y	28b. Time o	of 28c. Injury Work	y at k?	28d. Describe h	ow injury occurre	∌d	
<u>ö</u>	Attending r death. ector: Alter by the fune	atlc	2 Accident investigat	ion			Yes 2 □ No				
Division	r Att	ertification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home, farm, st Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Numbe m, State)	r or Rural Rou	ute Number,
	ital o	O		1							
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	(Check only 2 Medical Ex	Physicien: To the best of n aminer: On the basis of ex	amination and/or in	th occurred at the time to the time of time of time of the time of	ne, date and place pinion, death occu	, and due to the or rred at the time, or	cause(s) and man date and place, a	iner as stated. nd due to the	cause(s)
	the the mplet	Med	one)	and manner stated		29c. License	e number		29d. Dale signed	(Month Day	Veari
	To wit		29b. Signature and title of certifier	(Nama 11	1	110	)/ X.		211	105	
,	~		KALA	mark N		N/A	567		0146	111)	
	20		30. Name and address of person w	d completed dayse ordeat	Oly Killiam Sas Type	CATE PD3	in Amn	MAIR	400	(4N	
	1		31. Date filed (Month, Day, Year)	32. Remistrar's	Signature Signature	OHADLAS	NI WILL	110000	MY C	rut	
	Sta Registi		AUG 3 0	2005	J. 15 A	parte					
	3	2.45	AUG 3 U	CUUU KARANA		7					

Amend Item 3 per Dr., G847, 09/20/05dbb of Death

State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death

Reg. No. For A State Registrar Decedent's Name (First, Middle, Last)

Joseph 3. Time of Death **P. 11.** 4:47 am M 2. Date of Death Robert Sanchez Jr. Day Month Year **Physician** 28, August 2005 Sanchez /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Franklin Square Hospital Rosedale Baltimore 8. Date of Birth (Month, Day, Year)
April 23,1952 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Months Hours 1XM 2□ F 53 215 60 5197 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code with t Items 23e or 1803 Elk Rd. 21221 LISA Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. int: If item 27 is marked other than "naturel", or Items 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 25 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker Construction 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Joseph R. Sanchez Sr. Dorothy Crofoot 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1803 Elk Rd. Baltimore, Md. 21221 Debra Sanchez (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō 9/3/2005 Department of Important: If any injury or once. Lehi City Cemetery Lehi, Utah ' 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, 21. Signature of Funeral Service License 23a. Pakt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MyscARDIAL Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ğ 4 Pregnant at time of death 5 Other (specify) P.O. | detached the 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? Yes 22 No 2□ No 1 Yes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 P/Outpatient ٩ 1 🗌 Yes 2 No 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. M 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled within 24 hours a To the Funerel I 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 2 G S S 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 eath (Item 23a) (Type, Print) PPE and address of person who completed cause Year) State 0 Registrar

				State of Maryland / Department of Health and N State Certificate of Death		gien <b>2</b> 0 0 5	28353
		0.	de	Decedent's Name (First, Middle, Last)	2. Date of Dear	th	3. Time of Death
_		Physicia /Medic		Cynthia Ester Shaw	Mogth	28 2005	4:40 P M
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Death	
				Franklin Square Hospital Kosedale		Baltim	ore
		Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 If Under 1 Year If Under 24 Hrs.  Nonths Days Hours Min.	8. Date of Birth (Month, Day	Year) 9. Birth	place (State or Foreign intry)_
		Director		220-14-9128	June 1	6,1918 Penn	sylvania
	and	* * *		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary	fehow	ţō	Maryland Baltimore Essex			1 ☐ Yes 2 ☐ No
	the	r 28e	Director	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What Cou	intry?
	- A	23a o	ai D	1 Capri Drive 21221		U.S.A.	
1	dea	ems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
2	36 s afte	n that	by Fu	1 Never Married 2 Married 1 Yes XXNo	,	Specific	
-	d 21215-0036 filed with the Maryland	le Ex		XXWidowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation			White
+	15. 22. 22. 22. 22. 22. 22. 22. 22. 22. 2	"na Nextic	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	ring	16b. Kind of Business/li	ndustry
-	212	Hygiene. other then	E O	Elementary/Secondary (0-12) College (1-4or 5+)  1 Educator	:	School	
ynthi	ם פ	ital Hygiene. ud other then "naturel", or leems 23a or 28e-1 ehovevent, The Mudical Examerer must be notified at	BeC		e (First, Middle,	Maiden Sumame)	
O'	/ar	Aenta rkad rtic ev	To B	Henry Bowes Minnie Mi	ller		
	Maryland	i and 2 should be in the alth and Mental H item 27 le markad ot othar treumatic ever		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rur</i>			
2		ealth m 27 har tr		Sandra McNeal (Daughter) 812 Orems Road, Baltin			
2	altimore,	or other		XX Burial 2 Cremation 3 Deemoval from State cometery, crematory or other place)		20c. Location - City or T	
20	tim 2	tmen tent: jury		'4 Donation 5 Other (Specify) Orems U.M. Church Cem. 8/31		Baltimore,	-
Shaw	Bal	Department of Pages of Importent: If its any injury or of once.		21. Signature of Fundament Address of Eacility Bruzdzinski 1407 old Eastern A	Funera venue,	l Home, P.A Essex, Mary	iand 21221
•			-	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac sheck, or heart failure. List only one cause on each line.	or respiratory arr	est,	Approximate Interval Between
	P	hysician		Immediate Cause (Final disease or condition a Bilateral Pneumonia			Onset and Death
U		/Medical examiner		resulting in death)  Due to (or as a consequence of):			
		.xammer	_	Sequentially list conditions, b.			
	7	sit sol	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	-	sician and burial-transit	xar	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			
	8760, <	siciar s buris	dicai E				
	89	g physias the	edic	V			
	of Vital Records, P.O. Box 6	attending	Physician/Me	## FEMALE:  23b. If yes, outcome of pregnancy  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliv	very
	<b>D</b>	ne atte	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
	P.O.	by the a	hy	a Cl Ouxuowu			
	S,	igned b	by	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
	ord	been si	ompleted	Clastibules and i Diceasing	1 🗆 Y	es 2 No 3 □ Pro	bably 4 Unknown
	ec	has b	nple		24a. Was a autops	sy prior to c	opsy findings available ompletion of cause of
	H H	cate ha	Co		perfor 1 ☐ Yes	med? death? 2 No 1 Yes	2 No
	Vita	is certificate director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No			
	of Vital Records,	r this	. To	1 Yes 25 No Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Ciner: 4 Nursing Ho 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other (Spec ow injury occurred	ify)
	O	th. After funera	tion	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	200. 200000	ow injury cocarrod	
	Division	r dea	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (S	treet and Number or Ru	al Route Number,
		s afte	Certi	4 ☐ Homicide building, etc. (Specify)	City or Tow	n, State)	
	H 00 H	to the nashina of Attending Property within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	dical (	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the c red at the time, d	ause(s) and manner as date and place, and due	stated. to the cause(s)
	d d	ormple	Med	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Month	Day, Year)
		- s <b>⊢</b> ō		Ahmed MD 06133		8 (28 6	* * * * * * * * * * * * * * * * * * * *
		nΦ					
		20		Dr. Kirman Ahmed 9000 Franklin Square	Drive	Baltimore	4021237
	***	Sta	ate	31. Date filed (Month, Day, Year) 32. Reistrar's Signature			

State of Maryland / Department of Health and Mental Hygien 2005 28354 For State Registramend item #26 PER VERB C846 GE/Sifigate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1250 1 28 05 BRADLEY TELBY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HOWARD County GENERAL NOSp. +DL CoLumbia my YOWAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 21 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1**7** M 2□ F Hours 75 Jan Director 213-26-0651 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow te belillor of tau 1 ☐ Yes 2 X No MD Funeral Director Howard Ellicott City or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 11916 Frederick Road USA 238 21042 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, other treumetic event, the Medical Examinar Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Amusement Park 12 Maintenance Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked o Pages 1 and 2 should be Joseph Selby, Sr. Viola Easton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If of Health Mrs. Marlene E. Selby (Spouse) 11916 Frederick Road Ellicott City, MD 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ŏ Department of Importent: If eny injury or once. Crestlawn Mem. Park 8/31/2005 Marriotsville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician MYOCHADIA INFARCTION /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the John my Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physiclan/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0 detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 1 Yes 2 No Certification: To 3 DOA dence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 - Homicide within 24 hours a To the Funerel C filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier completely and manner stated. 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0017135 anna and address of person who completed cause of death (Item 23a) (Type, Print) 30. LAWRONCE 5450 KNOW WONTH, COLUMBIA, 5WINK M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2005 Registrar

		te gistrar		ryland / L	Certifica	nt of Hea	eath		g	05	2835
ysician Medical		dent's Name <i>(First, Middle, Last)</i> e <b>Doris Smith</b>	)					2. Date of De. Month August 27	Day	Year	3. Time of Death 10:10 A
aminer		4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Timonium				nty of Death timore	
ral tor	215-	07-5748	7. Age	(In yrs. last birt	hday) If Und Month		Under 24 Hrs. Hours Min.	8. Date of Bin June 24,	<sup>h</sup> 1915	9. Birth Mar	place (State or Forei ntay) Y land
5	10a. St			10c. City, Town Baltimor							10d. Inside City Lim
Funeral Director	10e. Str	eet and Number Winthrope Avenue		10f. Zip Code 21206				10g. Citizen o	of What Cou	ntry?	
by	3 💢	ital Status  Never Married 2 Married  Widowed 4 Divorced	ver in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
Completed	Elem	15. Decedent's Edu (Specify only highest grade entary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Doctor's Assistant					16b. Kind of Business/Industry  Medical		
To Be C	17. Fatl	ner's Nam <i>e (First, Middle, Last)</i> el Seitz	,		1	n. Mother's Nam <i>e (First, Middle, Maiden Suma</i> me) eatrice Friedell					
	19a. In	formant's Name/Relationship (Ty ne Gounaris/Daughte		-	•		Rural Route Number, City or Town, State, Zip Code) ville Maryland 21093			Code)	
	1 🕽	thod of Disposition  Burial 2 Cremation 3 F  Donation 5 Other (Specify)		20b. Place of cometer Garden	Disposition (A y, crematory o S Of Fai	lame of r other place) <b>th</b>	9/2/	Date /05	20c. Location	-	
SDC.	21. Sig	nature of Funeral Service Licens	and Address of arford R ore Mary	oad Lec	Leonard J. Ruck, Inc. 21214						
edical Examiner	Sequentification of the sequential sequentia	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE  Due to (or as a consequence of):  b. Due to (or as a consequence of).  c. Due to (or as a consequence of):  d.									Onset and Death
Physician/Me		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year		
þ	Part II.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							obacco use contribute to the cause of death? Yes 2□No 3□Probably 4▼Muknown		
Completed	-							24a. Was autor perfo 1 Tyes	rmed?	b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings avail impletion of cause 2 No
To Be Com	exa 1	25. Was case referred to medical examiner?  1  Yes 2 No								Other (Speci	fy)
·   -	27. Mai	27. Manner of Death  1 Matural 5 Pending (Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be			ime of njury M		3 □ No	28f. Location (Street and Number or Rural Route Number			al Route Number
-	2 3	Suicide 6 Could not be	28e. Place of Injur	28e. Place of Injury · At home, farm, street, factory, office  determined  28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)  28d. Cartifier  18 Cartifying Physician: To the best of my knowledge. Seath construct at the time, date and place, and due to the nause(s) and							
illed in by the funeral	29a C	Suicide 6 Could not be determined	building, etc.	."(Specify)	death onnium	ad at the time	date and clara	and due to the	nause(s) avid	merceres	
in by the funeral ertification:	295 G	Suicide   6   Could not be determined   Homicide   TX Certifying Physical Country   TX Certifying Physical Certification Physical Certification Physical Certifying Physical Certification Physical Certific	building, etc.	(Specify) I my knowledge examination and	d/or investigati	ad at the time on, in my opinion 29c. License nu	on, death occu	rred at the time,	date and place 29d. Date sig	e, and due t	stated o the cause(s)

			For State Registrar	- 10430	State of		nd / Dep		Health and		iene 20		283		
	Physici /Media	cal	1. Decedent's Name  SADIE  4a. Facility Name (If r			ner)		4b. City. Town	SMITH	2. Date of Deat Month AUGUST	Day	Year 005	3. Time o	A M	
	Examir Funeral Director	ier	SUBURBAN 5. Social Security Nur 159-34-7	HOSPIT	TAL		last birthday Yrs.	BETHE	SDA ar If Under 24 H		MONT	GOMER	y place (State ontry) PA	or Foreign	
D.		ctor		Decedent 10b. County	ERY		ly, Town or L						10d. Inside C	ity Limits	
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 6111 MONTROSE ROAD						10f. Zip Code 10g. 20852				ntry?		
020	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: If item 27 is marked other then "naturel', or items 23a or 28a-f show injury or other treumatic event. The Medical Examinar must be notified at injury or other treumatic event. The Medical Examinar must be notified at e.g.	by	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4		12. Was Decedor Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? XiNo	.S. 13.	Was Decedent of If Yes, specify C		(Specify Yes or No- erto Rican, etc.)		ck, White,	can Indian, etc. HITE		
0-61212	filed within 72 ho Hygiene. other then "natu ent, the Medical	Completed			Education rade completed) College (1-4	or 5+)	(Give	edent's Usual Oc e kind of work do. DO NOT use rel	cupation ne during most of v ired)	vorking	OWN I		dustry		
yidiid,	should be filed and Mental Hyg marked othe umatic event.	To Be C	17. Father's Name (F					HNER	BERTH				KOENIG	SBERG	
e, Mar	Health and I sho tem 27 Is me other treums		19a. Informant's Nam  LOIS STE  20a. Method of Dispo	INER /	(Type, Print) DAUGHTER	20b. I	1 FC	RSYTHIA	DRIVE SC	OUTH-LEVIT  Date	-	PA. 1	9056		
	permit. Pages 1 and 2 Department of Health a Importent: If item 27 li eny injury or other tre		1 ABurial 2 U 14 Donation 5	Other (Spec		ate	LOM ME	MORIAL 2. Name and Add	PARK 08/	31/2005 LG SOL LEVINS				١.	
	Physician		shock, or heart Immediate Cause (F disease or condition	failure. List ont	mplications that cau	h line.	h. Do not er	iter the mode of o		I ROAD - Pilac or respiratory arre		LE,	MD 212 Approximat Interval Bet Onset and	te tween	
,007	Ex Medicate be executed attending physician and for use as the burial-transit	dlcal Examiner	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):												
O. DOX O	w requires that the death certiff been signed by the attending should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1											te of delivery nth Day Year	
ords, r.	equires that t ien signed by ould be detai	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did to								bacco use contribute to the cause of death? es 2 □ No 3 ሺ Probably 4 □Unknown				
ng Physicien: The far fler this certificate has ineral director, page 2	n: The law r licate has be r, page 2 sh	Completed									ed? No	prior to co death?	psy findings mpletion of c 2□ No		
	nding Physicie th. :: After this certi e funeral directc	atlon: To Be	examiner?  1   Yes 2   X No								nce 6 Other (Specify)				
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:									l Route Num	ber,			
	To the Hospitel within 24 hours of the Funerel completely filled	Medical	(Check only 2 one)	☐ Medical Exa	Physicien: To the baminer: On the bas and manne	s of examina	owledge, dea ition and/or in	ivestigation, in m	y opinion, death oc	ce, and due to the ca curred at the time, da	te and place,	and due to	the cause(s	)	
	To To Mild		29b. Signature and til	le of certifier	form			D2	3 Q(9		d. Date signe	o (Month,	S Year)		
	8,	10	30. Name and address Lowe E 31. Date filed (Month)	S of person who	Completed cause	of death (Iter	n 23a) (Type	Print) USCOA	sin age	, Battes	DA, AL	1) 2	08(4		
	Sta Registr	-		AUG3 0	2005	seus.	J. I	goiste							

Smith sadie

State Registrar

completely filled in by

within 24 hours To the Funeral

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

AUG 3

0 2005

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 show amy injury or other traumatic event; Ite Mudical Event et must be rediffed at once.

Physician /Medical

Examiner

attending physician and for use as the burial-tran

detached

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

	State of Maryland Angular State of Maryland Angular State Pagistrar	/ Department of Health and Me -30-05 tas Certificate of Death		28358							
Physician /Medica Examiner	AUENE 1/1	4b. City. Town, or Location of Death	2. Date of Death Month Day Year AUGUST 21 LOS 4c. County of Dea	3. Time of Death 0-27 P M  th  MORE							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 213-32-3473 1 M 3/1 F 68	<b>`</b>	B. Date of Birth 9. Bir (Month, Day, Year)	thplace (State or Foreign ountry)							
Maryland a-f show	10a. State 10b. County 10c. City, T	own or Location Baltimore		10d. Inside City Limits 1 1 Yes 2 □ No							
with the Mai		10f. Zip Code 21201	10g. Citizen of What C	•							
be filed within 72 hours after death with the Maryland half Hyglene. Id other then "naturel", or Items 23a or 28e-1 show event, the Medical Ever and must be rediffed at Ref. Prompted by Funeral Director.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)  14. Race - Am Black, Whi								
of within 72 hours at ygiene.  The maturel, or it, it a Medical Every		6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Factory Worker	7	16b. Kind of Business/Industry  Fabric Factory							
- 0 - 0 5 2	17. Father's Name (First, Middle, Last)	18. Mother's Name (	(First, Middle, Maiden Sumame)  Delphine Ludd								
Marylan od 2 should be th and Mental 27 is marked treumatic ev		19b. Mailing Address (Street and Number or Rural 2837 Woodbrook Avenue Balt		Zip Code)							
ballimore, Marylar permit. Pages 1 and 2 should b Department of Health and Ments Importent: if liem 27 is marked eny injury or other treumatic e ones.	20a Method of Disposition 20b. Place	e of Disposition (Name of Da etery, crematory or other place)									
baltimor permit. Pages Department of I Importent: If its eny injury or o once.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Estab Brothers Funeral Service, P.A. 1300 Eutaw Place, Baltimore, Md 21217										
Physician /Medical	Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Disease or condition resulting in death)  Due to (or as a consequence of):										
ifrcate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence or):  c.  Due to (or as a consequence of):										
death cert e attending d for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ath 3 ☐ Ectopic pregnancy	23d. Date of de Month	23d. Date of delivery Month Day Year							
law requires that the as been signed by the 2 should be detache	Part II. Other significant conditions contributing to death but not results	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Junknown									
The lay		utopsy findings available completion of cause of									
Physicien: Physicien: Propertific  Propertif	25. Was case referred to medical examiner?  1										
DIVISION of or Attending Pater death. I Director: After din by the funeration of the funeration of the funeration.	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specify)	ural Route Number,									
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fun	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To the within To the comp	29b. Signature and title of certifier Rothkey, A	29c. License number D 43 491  Ba) (Type, Print) LOURT ROAD PANDAUS  A Species	AUGUST 2	th, Day, Year)							
4	30. Name and address of person who completed cause of death (item 23 M) WAFL ROTHKIN MD 5401 0 W	Ba) (Type, Print) LOURT ROAD RANDAU!	STOWN MARYUM	D 21133							
State Registra	31. Date filed (Month, Day, Year)  32. Registra Signature  AUG 3 0 2005	& Sparle									

State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death 28359 For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August **Physician** 27°, 2005 1:42 P. W Elizabeth Jane Thornton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8 Valleywood Court Baltimore County Timonium If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months Yrs. 17,1925 Director 358-12-0039 79 Kankakee, Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a State Item 27 is marked other than "naturel", or Items 23s or 28s-4 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Valleywood Court 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 le marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Operations permit. Pages 1 and 2 should be file Department of Health and Menial Hyy Important: If Item 27 ie marked other ony injury or other traumatic event, page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward Cantlin Margaret Conant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand Rapids, Michigan 49504 Mrs. Cynthia K. Gillham (Niece) 1445 4th Street N.W. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Evans Funeral Chapel Aug.30,2005 Forest Hill, Maryland 4 Donation 5 Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr.P.A. 2325 York Road Timonium, Maryland 21093 Path. Unter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder **Physician** 2 years disease or condition resulting in death) Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cleratic Cardiovas cular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the Director 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and Little of certifier 18667 e puty
e of death (Item 23a) (Type, Print)

6 Trimble H:11 CT: Luthonv: Ile, Mary land 21093
existent's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) My Militello, 31. Date filed (Month, Day, Year) 32. Registe r's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene200528360 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ELIZABET IALLAGSEN ALMA h:30 26 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. (Month, Day, Year) PERREYLVARIA ARUNOSI 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 ☑ F Yrs Director 21930 1931 MARYLANK Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ahow traumatic avant, the Medical Examiner must be notified at Director 1 Yes 2 □ No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Itema 23a AVS 8186 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after vital Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 € Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12785 Homemake AT Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) I and Mental A-KOBIRT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other tra W-TALLABSER 1ARYLANO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1≱ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) IZM. TARKVILLS 22. Name and Address of Facility— Pro 21. Signature of Funeral Service Licensee EMORIES 2034 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE HEXLY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ACRTIC SITHESIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physician and use as the burial-transit The law requires that the death certificate be executed ACRTIC BICUSPID that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) P.O. | cate has been signed by the page 2 should be detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2X No 1 Yes Hospital or Attending Physician: After this certification, I Be 25. Was case referred to medical 26. Place of Death (Check only one) GRAND DAVISTILL Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certification: To 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending NA death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 1 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (\$pacity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DO0 2500 HUGUST 29 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCRENA R. NELAN NO PARKVILLE MO 8831 SATYR HILL RD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2005 Been & Sperter Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005

Physic	ian -	Decedent's Name (First, N	fiddle, Last)							Date of Death Month	Day Ye	3. Time of Death	
/Medi		BAILEY		ITTY					a	ugust.	27 200	5 8:00 P	
Exami	ner	4a. Facility Name (If not instit				4b. C	ity, Town, or	Location of I	Death	7	4c. County of D	eath	
S W.	, 18 .	5. Social Security Number	arita 6. Sex	n Hospi	(In yrs. last b	inthday) If Un	altin	10Y-C If Under 24	Hrs. 8	Date of Birth	NA	Birthplace (State or Fore	
uneral irector		144.32.1250 Usual Residence of Deceden	XX	M 2□F	66	Yrs. Mont			Min.	(Month, Day, Yel	ear)	Country)  NC	
how		10a. State 10b. Co	unty	1	10c. City, To	wn or Location	·					10d. Inside City Lim	
r 28a-f show	Director	NJ ESSI	EX		NEWA	RK						1 Yes 2 I	
0 7	Dire	10e. Street and Number				10f.	Zip Code			10g.	Citizen of What	Country?	
n 23a	Funerai	52 ALEXANDI		12. Was Decedent Ev	or in 11 S	12 Was Da	071		2 /Casaib	. Van as Na	USA		
T Item	Fun	11. Marital Status 1 Never Married 2		Armed Forces?		If Yes, s	specify Cubar	spanic Origin n, Mexican, F	Puerto Rica	an, etc.)		merican Indian, Vhite, etc.	
lural', or al Exam	þ	3 Widowed 4 Divo	_	1 ☐ Yes <b>Y</b> X No If Yes, Give Year or Dates:		1 🗆 Yes	2 No <b>XX</b>	Specify:			Specify:	BLACK	
ical	Completed	15. Dece (Specify only hi	edent's Educ	cation	168	a. Decedent's U (Give kind of	Isual Occupa	ition	é working	166	o. Kind of Busine		
r than "r	npie	Elementary/Secondary (0-		College (1-4or 5+)	,	life. DO NO	T use retired)	)	working				
other than	Con	6				BUILD H					CONSTRU	UCTION	
9 0 6	Be	17. Father's Name (First, Mid						18. Mother's	Name (Fi	irst, Middle, Maid	den Sumame)		
marked matic e	ို	CHRISTOPHER								LIAMS T			
rau rau		19a. Informant's Name/Relat		de, Print)	19						ity or Town, State		
item 27 other tr		20a. Method of Disposition	<i>,</i> 5		20b. Place	of Disposition (		K KD.	Date		NC 27537 Location - City		
		XX Burial 2 Cremat		emoval from State		ery, crematory o		a) [	54.0	200	. Location - City	or rown, state	
important: if any injury o					ELMW					_n	ENDERSON	N, NC	
any in		ELMWOOD CEMETERY unk HENDERSON, NC  21. Signatur of aneral Service Licensee  PINK FUNERAL HOME, P.A.  426 CRAIN HWY SW GLEN BURNIE, MD 21061											
sician	li		ist only of	1 1 2		not enter the m	node of dying	, such as ca		spiratory arrest,		Approximate Interval Between Onset and Death	
sician ledical aminer	sai Examiner	Immediate Care (Final disease or con vion resulting in death).  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a a	Ventr Due to (or as a	consequence consequence	a not enter the many and a soft:  Can of):	node of dying	, such as ca	irdiac or re			Interval Between	
utending physician and cor use as the burial-transit	edicai	Immediate Calle (Final disease or confition resulting in death).  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as a of Due to (or as a of Severy	consequence consequence consequence pregnancy	e of):  Ary)  o of):  ulmora  o of):	nythm nythm nlism ny E	, such as ca	irdiac or re		23d. Date of Month	Interval Between Onset and Death	
utending physician and cor use as the burial-transit	Physician/Medical	Immediate Calle (Final disease or con hison resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	ditions con	Due to (or as a of Due to (or as	consequence consequence consequence pregnancy Fetal death ne of death	e of):  o of):  o of):  h 3 Ectopic  o Other  in the underlyin	pregnancy (specify)	nias nias nyofe clen	irdiac or re	spiratory arrest,	23d. Date of Month	Initerval Between Onset and Death Onset and Death  delivery Day Year	
signed by the attending physician and ui oi do detached for use as the burial-transit and	by Physician/Medical	Immediate Calle (Final disease or con hison resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	ditions con	Due to (or as a decorption of the control of the co	consequence consequence consequence pregnancy Fetal death ne of death	e of):  o of):  o of):  h 3 Ectopic  o Other  in the underlyin	pregnancy (specify)	nias nias nyofe clen	irdiac or re	23e. Did tobacc	23d. Date of Month	Initerval Between Onset and Death  delivery Day Year	
s been signed by the attending physician and Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Cons	by Physician/Medical	Immediate Calle (Final disease or con hison resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	a ditions connuctive	Due to (or as a of Due to (or as	consequence consequence consequence pregnancy Fetal death ne of death	e of):  o of):  o of):  h 3 Ectopic  o Other  in the underlyin	pregnancy (specify)	nias nias nyofe clen	irdiac or re	23e. Did tobacc 1 □ Yes 24a. Was an	23d. Date of Month  co use contribute 2 \( \text{No} \) 3 \( \text{Square} \)	delivery Day Year The cause of death? Probably 4 Pohknow	
Ite has been signed by the attending physician and in or or oage 2 should be detached for use as the burial-transit	by Physician/Medical	Immediate Calle (Final disease or con Nion resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE  23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant con Chronic Obst.	a ditions connection	Due to (or as a decomposition of the program to the program to the program to death but to pulmon.	consequence consequence consequence pregnancy Fetal death ne of death	e of):  o of):  o of):  h 3 Ectopic  o Other  in the underlyin	pregnancy (specify)	nias nias nyofe clen	thy	23e. Did tobacc 1 ☐ Yes  24a. Was an autopsy performed	23d. Date of Month  co use contribute 2 \( \text{No} \) 3 \( \text{Square} \)	delivery Day Year  The to the cause of death?  Probably 4 Proknow autopsy findings availat to completion of cause of	
Ite has been signed by the attending physician and in or or oage 2 should be detached for use as the burial-transit	e Completed by Physician/Medical	Immediate Calle (Final disease or con hison resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	aditions connection	Due to (or as a of Due to (or as	consequence consequence consequence pregnancy Fetal death ne of death	e of):  o of):  o of):  h 3 Ectopic  o Other  in the underlyin	pregnancy (specify)	nies Sanger and Sanger	thy.	23e. Did tobacc 1 ☐ Yes  24a. Was an autopsy	23d. Date of Month  co use contribute 2 \( \text{No} \) 3 \( \text{Square} \)	delivery Day Year  a to the cause of death? Probably 4 Ponknov autopsy findings availat to completion of cause of	
Ite has been signed by the attending physician and in or or oage 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Immediate Calle (Final disease or con hison resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE 23b. Was decedent pregnant in the past 12 months?  1	aditions connection	Due to (or as a of Due to (or as	consequence consequence pregnancy Fetal death not resulting	a of):  a of):  b of):  h 3 sectopic 5 other  in the underlyin	pregnancy (specify)	n in Part I.	thy.	23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1  Yes 2  Preck only one	23d. Date of Month  co use contribute 2 \( \text{No} \) 3 \( \text{Square} \)	delivery Day Year  a to the cause of death? Probably 4 Prohimore autopsy findings availat to completion of cause of	
filer this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit in inneral director.	To Be Completed by Physician/Medical	Immediate Calle (Final disease or con vision resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE. 23b. Was decedent pregnant in the past 12 months?  1	a ditions connuctive Me // dical	Due to (or as a of Due to (or as	consequence consequence pregnancy Fetal death not resulting	a of):  a of):  b of):  h 3 sectopic 5 other  in the underlyin	pregnancy (specify)	n in Part I.	Death Cr	23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1  Yes 2  Preck only one	23d. Date of Month  co use contribute 2 No 3 Contribute 2 No 3 Contribute 2 No 3 Contribute 2 No 3 Contribute 2 No 3 Contribute 2 No 3 Contribute 3 A Contribute 4 A Contribute 5 A Contribute 6 Contribute 8 A Contribute 8 A Contribute 9 A Contribu	delivery Day Year  a to the cause of death? Probably 4 Prohimore autopsy findings availat to completion of cause of	
filer this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit in inneral director.	To Be Completed by Physician/Medical	Immediate Calle (Final disease or con hison resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	additions connective dical H	Due to (or as a of Due to (or as	consequence consequence pregnancy Fetal death not resulting  2 Pro 2 ER/O (ear) 28b.	a of):  a of):  b of):  a of):  h 3   Ectopic   5   Other  in the underlyin    D   S   C    uutpatient 3   Time of   Injury   M	pregnancy (specify)  g cause gives  DOA Other  28c. Injury Work' 1 U	n in Part I.	Death Cring Home	23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1 Yes 2  Teck only one)  5  Residence Describe how in	23d. Date of Month  20 use contribute 2 No 3 2  24b. Were prior death 1 Yes 6 Other (Sinjury occurred	delivery Day Year  a to the cause of death? Probably 4 Prohimov autopsy findings availat to completion of cause of the cause of the cause of the cause of the completion of the cause of the completion of the cause of the completion of the cause of the completion of the cause of the completion of the cause of the caus	
filer this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit in inneral director.	To Be Completed by Physician/Medical	Immediate Calle (Final disease or con hison resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE. 23b. Was decedent pregnant in the past 12 months?  1	additions connuctive Mellidical H	Due to (or as a of Due to (or as	consequence consequence consequence pregnancy Fetal death not resulting 2 EP/O (*ear) 28b.	a of):  a of):  b of):  a of):  h 3   Ectopic   5   Other  in the underlyin    D   S   C    uutpatient 3   Time of   Injury   M	pregnancy (specify)  g cause gives  DOA Other  28c. Injury Work' 1 U	n in Part I.	Death Cring Home 28d.	23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1 Yes 2  Teck only one)  5  Residence Describe how in	23d. Date of Month  20 use contribute 2 No 3 2  24b. Were prior death 1 Yes 6 Other (Sinjury occurred	delivery Day Year  to the cause of death? Probably 4 Denknov autopsy findings availate to completion of cause of	
filer this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit in inneral director.	Certification; To Be Completed by Physician/Medical	Immediate Called Final disease or con Nion resulting in death.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant con Chronic Obst.  Hypertension  25. Was case referred to merexaminer? 1   Yes 2   No 27. Manner of Death 1   Natural 5   Pe 2   Accident 3   Suicide 6   Co de 4   Homicide   Control of Contr	aditions connective dical Humaning estigation and be termined	Due to (or as a description of the policy of	consequence consequence consequence pregnancy Fetal death not resulting 24 Fe/O (Fear) 28b. The At home, f (Specify) The Monwelding grammation as	and enter the man and and and and and and and and and a	pregnancy (specify)  g cause gives  28c. Injury Work  1 Y	n in Part I.  26. Place of F. 4   Nursin at ?  e. date and n	Death Cring Home 28d.	23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1  Yes 2  Teck only one) 5  Residence Describe how in	23d. Date of Month  20 use contribute 2 No 3 2  24b. Were prior death 1 Yes 6 Other (S) njury occurred	Interval Between Onset and Death Onset and Death  delivery Day Year  a to the cause of death?  Probably 4 Priknov autopsy findings availate to completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of the cause of t	
filer this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit in inneral director.	To Be Completed by Physician/Medical	Immediate Calle (Final disease or con hison resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	anditions consuctive dical Hunding restigation and not be termined ifying Physical Examination and the second consumption of the second consumption	Due to (or as a of Due to (or as	consequence consequence consequence pregnancy Fetal death not resulting 24 Fe/O (Fear) 28b. The At home, f (Specify) The Monwelding grammation as	utpatient 3  Time of Injury  Marm, street, factoring of the courrend/or investigation	pregnancy (specify)  g cause gives  28c. Injury Work  1 Y	n in Part I.  26. Place of at a larger at	Death Cring Home 28d.	23e. Did tobacc  1  Yes  24a. Was an autopsy performed to the cause to the cause to the time, date in	23d. Date of Month  20 use contribute 2 No 3 2  24b. Were prior death 1 Yes 6 Other (S) njury occurred	Interval Between Onset and Death Onset and Death Death Death Death Death Death Death Death Probably 4 Probably	
If this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit in inneral director.	Medical Certification; To Be Completed by Physician/Medical	Immediate Calle (Final disease or con hison resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant con Chronic OST  Hypertension  25. Was case referred to merexaminer?  1   Yes 2   No 27. Manner of Death  1   Matural 5   Pe 2   Accident inv 3   Suicide 6   Co de de de de de de de de de de de de de	additions connection  addition   Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or and Due to (or as a of Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or and Due to (or as a of D	consequence consequence consequence pregnancy Fetal death not resulting  2 EP/O (ear) 28b. At home, f (Specify) my knowledg xamination and	and enter the man and and and and and and and and and a	pregnancy (specify)	n in Part I.  26. Place of F. 4 Nursinat ?  es 2 No	Death Cring Home 28d.	23e. Did tobacc  1 Yes  24a. Was an autopsy performed 1 Yes 2 Theck only one)  5 Residence Describe how in  Location (Street City or Town, St due to the cause the time, date a	23d. Date of Month  20 use contribute 2 No 3 2  24b. Were prior death 1 Yes 6 Other (Sinjury occurred  and Number or tate)  2(s) and manner and place, and death of the month	Interval Between Onset and Death Onset and Death		

State of Maryland / Department of Health and Mental Hygien 2005

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:15 AM M. Thomas Joveen 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death **Examiner** CHESTER FIRD BACTIMORE HVE. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 ■ M 2 F Days 217.80.8316 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or Items 23a or 28e-f show the Medical Exercine must be notified at 1 Yes 2 □ No Director SAUTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 Is marked other then "natural", or Items 23 Funeral 14. Race - American Indian, Black, White, etc. 11. Marital/Status Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ORRECTIONAL STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4408 ROAD APT. 2 MORAVIA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of P Importent: If ite any injury or of once. cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMURIAL PARK 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility VANCHIN C. GLEENE FUNCKAL Hom tates of Funeral Service Licensee KOAD BAITIMORE, MARYLAND 2012 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence ): Physician disease or condition resulting in death) /Medical Examiner meta static ovaviou Sequentially list renditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): burial-t attending physicien for use as the buria Box 68760. The law requires that the death certificate be Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) P.O. the 9 Unknown ate has been signed in page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by pleuvo 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 ☐ Yes Division of Vital 1 Yes the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide filled in 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31087 25105 16 Burlin, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter K. Zucker, with all2411 W. Belvedeve Ave. Suite 206 32. Registrar's Signal 31. Date filed (Month, Day Year) Baltimore, MD 21215 State Registrar

		1	For State	State of Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M D <i>eath</i>		giene20	05	28363
			Registrar  1. Decedent's Name (First, Middle, Last	1)				2. Date of Dea	ath		3. Time of Death
	Physicia	_	Leon Woods Till					Aug.	25 20	Yeer 005	2:00 A M
<b>&gt;</b>	/Medic Examin	_	4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Death	/ tag.	4c. County	-	2.00 /
	CXAIIIII	e1	12107 Tullamore	Ct. Unit 304		Timoniu	ım		Bal	timor	·e
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	h v Year)	9. Birthp	lece (State or Foreign
	Director		228-20-6908	<sup>2 M 2 □ F</sup> 77	Yrs.	MOINTS Days	110013	July 26		VA	
	P .		Usuel Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	postion				1	0d. Inside City Limits
	aryla shov	-	MD Baltimo		moniun					'	1 ☐ Yes 2 M No
	8 - F	Director		16	moman				10g. Citizen of W	/hat Cour	
	with the	吉	10e. Street and Number	2. "20"		10f. Zip Code			100	mat Coun	my:
	e 23	Funeral	12107 Tullamore (	12. Was Decedent Ever in U	18 13	21093	spanic Origin? (Sp	ecify Yes or No	USA 14. Race	- Americ	ean Indian,
	Item	Š	11. Maritaf Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 € No	J.S. 10.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Blac	k, White,	etc.
<u></u>	be filed within 72 hours after death with the Maryland hal Hygiene. do other than "netural", or terme 23a or 28a-f show event, the Medical Exertical must be notified at	by	3 Widowed 4 Divorced	ff Yes, Give Year or Dates:		1 ☐ Yes 2√€ No	Specify:		Specify	:	white
21215-0036	2 hou		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Bu	siness/Inc	dustry
212	fited within 72 Hygiene. other than "nei ent, the Medic	Completed	(Specify only highest grad Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life.	DO NOT use retired	) )	mg	Wholes	ale	
7	d with	E C	12	n/a	Sale	sman			Plumbin		Heating
Maryland	be fite stal Hy od oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumam	e)	
<u>la</u>	should be ind Mental marked c	2	McDouglas Tillet	t			Elsie Pa				
a	and and ie m		19a. Informant's Name/Relationship (7			ng Address (Street					
	es 1 and 2 should b of Health and Ment litem 27 ie marked r other traumatic e	1	Page Arkerson T			7 Tullamo		304, 111	20c. Location -		
altimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □	Removal from State	cemetery, crea	matory or other place	8/27	7/05			
<u>E</u>	men tant: jury		* 4 □ Donation 5 □ Other (Specify		laney '	Valley Me	morial Ga	ardens	Timoniu	n. M	D
Ba	permit. Pages Department of Importent: If it eny injury or o		21. Signature of Funeral Servine Licen.			2. Name and Address Lemmon F		ome of	Dulanev	Val	Jey, Inc.
	10 = 0 U		23a, Part 1, Enter the disease, or comp	Ole  blications that caused the dea	th Do not en	Lemmon F 0 W. Pad	onia Rd.	, Timon	nium, Mi	210	Approximate
П			shock, or heart failure. List only of	one cause on each line.	-		9, 50011 45 541 5145	or roopmatory at			Interval Between Onset and Death
} -	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a LUNG		286					4 YEARS
	Examiner			Due to (or as a conse	quence or):						
	ay.	<u>e</u>	Sequentially list conditions,	b. Due to (or as a cones	quenne of):						
Ý	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events								
C C	exector and and and and and and and and and and	Exa	resulting in death) Last	Due to (or as a conse	quence of):						
8760,	icate be executed physician and the burial-transit	dicai		. d							
9	rtifica ng ph	a	IF FEMALE:							1	1.
Вох	leath certific attending p I for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	tal death 3[	⊒Ectopic pregnancy	,		23d. Dat	e of delive	ery Day Year
	The law requires that the death certifi ste has been signed by the attending cage 2 should be detached for use as	Physician/M	1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5[	Other (specify)					,
0.	that the de led by the a detached f	Phy	Part II. Other significent conditions or	ontributing to death but not re	sulting in the c	inderlying cause giv	en in Part I	23e, Did t	obacco use conti	ribute to th	he cause of death?
S,	ires tha signed I be de	by		erve Peur	-	-	15 E	10	Yes 2□No	3 🗌 Prot	pably 4 Donknown
0.0	w requir been si should	etec		EART FAILE			11.00	24a. Was	20 24h 1	Nore auto	ppsy findings available
Vital Records,	has ge 2 s	Completed			1	CONSON	Trey	autor	osy ormed?	prior to co	mpletion of cause of
a	icien: Th certificate rector, pag		ARTERY DIS	EA-5 E			ac Phase of Deep	1 Yes		Yes	2∐ No
	Physicien: r this certifica ral director, i	o Be	25. Was case referred to medical examiner?	Hospital:	☐ ER/Outpatie	oth Oth	er: 4 Nursing H	ome 5 Danesi		or (Special	(v)
Division of	Phys r this ral di	<b>!</b>	1 Yes 2 No	28a. Date of Injury	28b. Time d				how injury occurr		7/
on	Attending I or death. ector: After by the funer	tlor	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	Injury	M 1	k? Yes 2 □No				
/ISI	or Attendation of Director:	ifica	3 Suicide 6 Could not be determined	288. Place of injury - At	home, farm, st	reet, factory, office		28f. Location (. City or Tox	Street and Numb	er or Rura	al Route Number,
á	s afte	Certification:	4   Hottiicide	building, etc. (Spec	uny)			ony or ro	mi, olato,		
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page			ysicien: To the best of my kr niner: On the basis of examin							
	the H in 24 the F iplete	ledical	one)	and manner stated.							
	To To	Σ	29b. Signature and title of certifler			29c. Licens			29d. Date signe		
7	+		you l				3095		queerst	25	2005
	8		30. Name and address of person who						005		
			Eric Carr, M.D 31. Date filed (Month, Day, Year)	32. Redistrar's Sign	nature		i imonium,	MD 21	U93		
	Sta Regist		AUG 3 0	. 27	16	Code					
0.1		004	1.500	JAN TOUR	10						

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30A **Physician JAMES** HOWARD TIMMONS HAMES HAROLD TIMMONS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ed Ale
If Under 24 Hrs. 8. actimore PITA () Franklin 1705 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 → M 2 □ F Months Days Hours Min. MD. Director 219-28-3352 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No BALTIMORE Director N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 UNITED STATES 3009 O'DONNELL STREET Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1951 If Yes, Give Year or Dates: 1953 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 🗓 No Specify: Specify: 1953 3 Widowed 4 Divorced item 27 is marked other then "neturel", other treumetic event, the Madical Ex. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) **ENGINEER** JOHNS HOPKINS 12TH Department of Health and Mental Hyg Importent: If item 27 is marked otherwising or other war. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TINKNOWN UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6520 COLGATE AVE., BALTIMORE, MARYLAND 21222 JAMES TIMMONS, JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8/27/05 BALTIMORE, MARYLAND `4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease of sort shock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician Obx disease or condition resulting in death) /Medical Examiner 'eymov Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Box 68760, Physiclan/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by HODATOCE LUAR 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. Medical 29a. Certifier (Check only one) npletely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DO058671 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Backimore Md 21237 10 JON 116 2000 Franklin AUG 3 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28365 For state Registrar amend item #10b per fh 8846 **Gertificate of** Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 32DM GILORIA 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey
5. Social Security Number 6. Sex Balhmore der 1 Year | If Under 24 Hrs. House If Under 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗹 Months Days Hours Min. December 1,1938 Director 6 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits i and Marial Hygiene. Is marked other then "natural", or Iteme 23a or 28e-1 ehov reumatic event. The Medical Examinar must be notified at 1 Pres 2 No Director Itimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4026 21229 USA -rederick Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Newer Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Yes. Give Specify white 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NUSING treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Homer T. BrissON -lorence ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is eny injury or other tree GTORIA FENWICKcaughter 2426 RaptoRDR. Oden ton ms 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Oc. Location - City or Town, State Date Bayrica Cremtory 4 □ Donation 5 □ Other (Specify) 105 21. Signature of Funeral Service Licenses Bradley-Ashlow & 134 Willow & FUNERAL Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) carcinome Physician bush /Medical Due to (or as sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 25 No 9 ☐ Unknown this certificate has been signed by the al director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Ses 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1☐ Yes 2☐ No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specific Light Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation М 2 Accident Director: / 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) of certifie 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (50) SOCTUS

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 2005

3. Registrar's Signature

		•	For State Registrar	State of Ma	ryland / D	epartment of Certificate of	f Death	R	eg. No.	005	28366
		-	Decedent's Name (First, Middle, Last)					2. Date of Deal Month	th Day	Year	3. Time of Death
	Physicia /Medic		Dorothy Patricia	Tuck				August		005	9:00 AM <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Death		4c. Cou	nty of Deeth	
			353 Savannah Roa	d			timore				
	Funeral		5. Social Security Number 6. Sex	7. Age M 2. ☑ F	(In yrs. last birth	Months Day		8. Date of Birth (Month, Day	, Year)	9. Birthp Coun	lace (State or Foreign try)
	Director		210-00-030-	M ZXI	63 Y	rs.		Jan 17,	1942	Mary	land
	pu 💌		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
	sho	2			•	Baltimor	0				1- Yes 2 No
	Ne M	Director	MD 10e. Street and Number			10f. Zip Code		1	Og. Citizen	of What Coun	
	Mith t	급									,
	s 23	Funerai	353 Savannah Road	1 2. Was Decedent E	ver in U.S.		21221 f Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No-		SA Race - Americ	an Indian,
	Item Item	'n.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N				Rican, etc.)		Black, White,	etc.
36	Irs af	by	3 Widowed 4 Divorced	If Yes, Give 22 Year or Dates:		1□Yes 2√√N	o Specity:		Spe	ocify: wh	ite
ğ	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "netural", or items 23a or 28a-f show event, the Medical Examinar must be invitiled at	ted	15. Decedent's Educa	ation	16a. I	Decedent's Usual Occ (Give kind of work don	upation	rina	16b. Kind of	f Business/Inc	dustry
21215-0036	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT use reti	red)	ung			
7	d wit	COL	8	0		homema				wn hom	e
g	at Hygie I other vent,	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sun	nam <i>e)</i>	
Maryland	Mental Merked o	2	John Oscar Ludwig	g Anderso				hy Emma			
a	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Mental Count, County Count	8	19a. Informant's Name/Relationship (Typ	e, Print)		Mailing Address (Stre					Code)
≥,	and ealth m 27		Ken Tuck/spouse			53 Savanna	h Koad Bal	Date Date		1221 on - City or To	um Clata
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ex		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  4 ☑ Donation 5 ☐ Other (Specify)	moval from State	cemeter)	Disposition (Name of y, crematory or other p					
Balt	permit. Departr Imports any inji		21. Signal tre of Funeral Service Litense	ade, Bir	of the	2. Name and Add State Ana Baltimore	tress of Facility Ltomy Board MD 2120		Balti	lmore S	Street
	<b>*</b>		23a. Part1. Enter the disease, or complice shock, of heart failure. List only one	ations that caused	the death. Do n				est,		Approximate Interval Between
	Physician		Immediate Cause (Final	e cause on eaching	- J	~ 0 -					Onset and Death  QUELTS
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of	of):					2010
в	Examiner		A CONTRACTOR OF THE PARTY OF TH								
_		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as i	r consequence o	0:					
	ficate be executed physician and is the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ó,	e exe ian a urial-	Ē	resulting in death) Last	Due to (or as a	a consequence o	of):					
38760,	ate b hysic he bi	edical	d							-	
9	ing p		IF FEMALE:			0.0	****				
Box	es that the death certifigned by the attending be detached for use at	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 Live birth	2 Fetal death	3 Ectopic pregna			23d.	Date of delive Month	Day Year
0	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 ☐ Other (specify)					
P.O.	faw requires that the as been signed by th 2 should be detache	Ph	Part II. Other significant conditions con	tributing to death bu	ut not resulting in	the undertying cause	given in Part I.	23e. Did to	bacco use c	contribute to the	ne cause of death?
Š,	ires ti signe d be d	þ	Tarris out		•	,		1 54	es 2 🗆 N	o 3 🏻 Prob	ably 4 Unknown
oro	w require been si should b	Completed						24a. Was	20	th More auto	psy findings available
Sec.	has by	du						autop	sy	prior to co death?	mpletion of cause of
트	The page							1 ☐ Yes	2 No	1 🗌 Yes	2 No
Zi Zi	ician: Th certificate rector, paç	Be	25. Was case referred to medical examiner?	ospital:	- C		Othor	th (Check only o		0	
of Vital Records,	Physician: this certific ral director.	To T	1 Yes 2 No	1 Inpatie	nt 2 ER/Out	tpatient 3 DOA	4 🗀 Nutsing n	ome 5 Hesid			y)
	Jing After funer	io	√Natural 5 ☐ Pending	(Month, Da)		njury V	Vork? □Yes 2□No		, ,		
Sic	Attending or death.	lical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At home, fa	rm, street, factory, offic	Э	28f. Location (S	Street and No	umber or Rura	I Route Number,
Division	after Direction by	Certification:	4 Homicide determined	building, etc	. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	m, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director.	ledical C	29a. Certifier Certifying Physical (Check only one)	ician: To the best er: On the basis of and manner sta	examination and	dor investigation, in m	e time, date and place y opinion, death occu	, and due to the or rred at the time, or	cause(s) and date and pla	d manner as s ce, and due to	tated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier				ense number		0/2	gned (Month,	
			30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (		1801 =	BALTO	MD	212	137
	CA	210	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	1. 1.			/		
	SI Regist	ate rar	AUG 3 0 200	5 Krew	J. K.	Good					
	3	1,3	AUG 3 U ZGO	-		/					

			1- State of Maryland / De State of Maryland / Co	partment of Health and Mertificate of Death	lental Hygi	ene 2005	28367
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic		Arthur E. Vogel		August		2:15p M
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			512 Cedar Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ESSEX  If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Baltimo:	re hplace (State or Foreign
	Funeral Director		216-28-2698 1 NM 2 F 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 7, 1		ryland
			Usual Residence of Decedent		1 CD . / p	920	
	show	<u>_</u>	10a. State   10b. County   10c. City, Town or   MD   Baltimore	Essex			10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	
	3a or		512 Cedar Ave.	21221		USA	and,
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	3. Was Decedent of Hispanic Origin? (Spo If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame Black, White	
စ္တ	or Ite	y Fu	1 Never Married 2 Married 1 Never Married 2 No	1 ☐ Yes 2 ☒ No Specify:	ritouri, oto.,	Specify: Wh	
Ö	hours tural',	ed by	3 Wildowed 4 Divorced Year or Dates:	cedent's Usual Occupation	10	6b. Kind of Business/	
5	in 72 n "na	plet	(Specify only highest grade completed)  (Gillementary/Secondary (0-12)  College (1-4or 5+)	ve kind of work done during most of work DO NOT use retired)	ing	Beth Ste	
212	giene giene er tha	Completed	10th	Steel Roller		beth but	
Maryland 21215-0036	be file ital Hy id oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Sumame) usta Hea	+ h
Z Za	d Men marke	ို	Charles E. Vogel  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	ulling Address (Street and Number or Rura			
Ma	id 2 st Ith and 27 Is r traur			26 MAple Ave.Bal			LP Code)
ē,	s 1 ar f Hea item i		20a. Method of Disposition 20b. Place of Dis			0c. Location - City or	Town, State
Ë	Page nent o int: If iry or		1 Structural 2 Cremation 3 Hemoval from State		1/05	Baltimor	e MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examination must be retified at ance.		21. Signature of Funeral Service Licens e	22 Name and Address of Escility		uneralHo	meofEssex
	20 E 2 9		K. fermonnelly	300 Mace A	ve.Balt	imore MD	21221
П			23a. Part1. Enter the disease, or complications that caused the doest. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a	9			morns
	Examiner						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin.  Due to (or as a consequence of):				
	ecuted and transi	ami	Cause (Disease or injury that initiated events c.				
8760,	be exician sician s	dical Examiner	resulting in death) Last Due to (or as a consequence of):				
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		d				
Box	h certi	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of del	
B	that the death cer ed by the attendin detached for use	sicie	1 Yes 2 No 4 Pregnant at time of death	5 ☐ Other (specify)		Month	Day Year
P.O.	hat the d by t setach	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did toba	acco use contribute to	the cause of death?
ds,	w requires that s been signed b should be det	d by	COPD Atrial Fib	illation	1 ☐ Yes		
COL	w requ	Completed			24a. Was an	24b. Were au	topsy findings available
Re	The lav	omp			autopsy perform	ed2 prior to death?	completion of cause of
<u>ta</u>	ian: ]	BeC	25. Was case referred to medical	26. Place of Death			20110
× ×	Physician: this certifica ral director, p	To	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		-	nce 6 □Other (Spec	cify)
UC C	ling P	ion:	27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time (Injury)		28d. Describe hov	v injury occurred	
Division of Vital Records,	Attending ir death. ector: Alter by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm.		28f. Location (Stre	eet and Number or Ru	ıral Route Number,
<u>S</u>	al or A s after if Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely triled in by the funeral director, page	edical (	29a. Certifier (Check only Medicel Examiner On the best of my knowledge, de	eath occurred at the time, date and place,	and due to the cau	use(s) and manner as	stated.
	the Hin 24 the F	Medi	one) and manner stated.  29b. Signature and title of pertitier	29c. License number		d. Date signed (Monti	
	70 Wit	-	Sur Digital dia dia dia dia dia dia dia dia dia dia	Dural 9	29	Q/2/1	1
1	77		30. Name and address of person who completed cause of death (Item 23a) (Tyr	pe, Print)		010910	) )
	1 1		Bayview Hospit		Balti	more MD	
	Sta		21 Date filed (Month Day Year) 32 Registrar's Signature	Sparke	•		
	Registi	ar	AUG 3 0 2005 Status &	Market .			

State of Maryland / Department of Health and Mental Hygiene 2005

			State of Maryland / Department of Health and I  Certificate of Death		28368
	т п.		1. Decedent's Name (First, Middle, Lest)	Reg. No.  2. Date of Death	3. Time of Death
	Physici /Media		arlene Judith Winfield	S 21 FY	4:45 Pm
	Examir		4a Facility Name (If not institution, give street end number)  4b. City, Town, or I		
			Ninon Memoral Hospital Balling  5. Social Security Number 6. Sex 7. Age (In yrs. lest biginday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthp	lana (Stata or English
Р	Funeral Director		213 80 4659 1 M 2 Months Days Hours Min.		lace (State or Foreign
		l	Usuel Residence of Decedent		regime
	arylar show	-	10a. State 10b. County 10c. City, Town or Location Baltimore	1	0d. Inside City Limits 1  Yes 2  No
	28a-f	Director	10a Street and Number A + A + A 10f Zin Code	10g. Citizen of What Coun	
	hours after death with the Maryland ural', or Items 23a or 28a-f show al Examiner must be notified at	2	3208 Cliftmont Ave. 21213	USA	,.
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban Mexican, Puert	pecify Yes or No- o Rican, etc.) 14. Race - Americ o Black, White,	
20	s afte	by F.	1 Never Married 2 Married 1 Yes 2 10 No Specify:	Specify:	Jack
21215-0020	72 hours "natural", edical Ex	<b>8</b>	3 ☐ Wildowed 4 ☐ Profession	16b. Kind of Business/ind	dustry
215	within 72 ena. than "nat	Completed	(Specify only highest grade completed)/  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)  A V Care V o V	king	
	77	Con	1207		
and	I be filed ntal Hyg ad othe event,	Be	17. Father's Neme (First, Middle, Last)  18. Mother's Nam  Connect  18. Mother's Nam	ne (First, Middle, Maiden Surname)	
aryland	should nd Me mark imatic	၉	19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Ru	ural Route Number, City or Town, State, Zip	Code)
ž	and 2 alth a 27 is	1	Brenda Jones (Sister) 4/11 Raymono	we Batto, med 2	1213
ore	ges 1 to He if itam		20a. Method of Disposition (Name of Commentary comments)	Date 20c. Location - City or To	wn, State
Baltimore	THE B		4 Donation 5 Other (Specify),	5/27/05 Belliner,	Mol
Bal	permit. Departmimportal any inju		21. Signature of Funeral Service Licensee 22. Name and Address of East-lifty		ome
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	er respiratory arrest	Approximate
1	Physician		shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
1	/Medical Examiner		Immediate Ceuse (Final disease or condition e ASPIRATION PNEUM	ONIA	
Н	LXammer	_	Due to (or es a consequence of):	1	
	utad d ansit	E I	Sequentially list conditions,  b. QUDRIPLEGIA  Due to (or as a consequence of):		
ó	an an	Exa	if eny, leading to immediate cause. Enter Underlying	4 (F	
8760,	ficate be executed physiclan and is the burial-transit	dical Examiner	Ceuse (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	7130	
	ding p	<b>⊕</b> ∣	d		
Вох	v requiras that the death certif been signed by the attending should be detached for use a	Physician/M	Dottl. Other classificant and title an excellent a back but a trackline in the carterial in Data.	23b. Did tobacco use contribute to	the source of death 2
P.O.	t the c by the tacher	hys	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes 2 ☐ No 3 ☐ Prob	.0
s,	as tha igned be de	þ			
oro	requir	Completed		performed? ava	re autopsy findings tilable prior to npletion of cause
	elaw hasb ge2s	ig I		of c	leath?
<u>e</u>	n: The ficate or, pag		25. Was case referred to medical 26 Place of Dea	1 J Yet 2 Mu 1 Check only one)	Yes 2□ No
<u>=</u>	/sicial s certi directo	To Be	examiner?	ome 5 ☐ Residence 6 ☐ Other (Specify	,
0	g Phy ter thi neral	L:us	27. Menner of Death 1 D Naturel 5 □ Pending   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?	28d. Describe how injury occurred	
sio	eath. cor: Af the fu	catic	2 Accident investigation M 1 Yes 2 No		
Division of Vital Records,	or Att	Certification:	3 ☐ Strictor Stricto	28f. Location (Street and Number or Rura City or Town, State)	Houte Number,
	To the Hospital or Attending Physician: The law within 24 hours afta death. To the Funeral Director: After this certificate has complately filled in by the funeral director, page 2	S C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	, and due to the ceuse(s) and manner as st	ated.
	ha Ho in 24 I he Fui plataly	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, date and place, and due to	the cause(s)
	Mith Tot	Σ	29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, I	Day, Year)
	(2)		1 8milli mg 13027-	2 8/25/	2005
(	5/		30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)  THOMAS S. MILLER 3601 O'DONNER S	I BAUTIMONE,	MD.
	Sta	te	31. Date filed (Month, Day, Yeer)  ALIC 3 0 2005		

			For State Registrar		C	ertificate of l			eg. No.	3. Time of Death
E	Physici /Medio		1. Decedent's Name (First, Middle, La Theresa L	wh	te			Ava 3	D	
	Examin		4a. Facility Name (If not institution, giv University of Maryli		nl Center		Location of Death	J	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. S		63 Yrs	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/25/19	Year) Co	hplace (State or Foreign nuntry)
	Maryland f show	ior	Usual Residence of Decedent  10a. State 10b. County  Marray 1 and		10c. City, Town or					10d. Inside City Limits
	sa or 28a	Funeral Director	Maryland   10e. Street and Number 1115 North Fulton	Avenue	ball	imore 10f. Zip Code	1217	10	0g. Citizen of What Co	ountry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "naturel; or Items 23a or 28a-f show other traumatic event, the Medical Eva in act must be mailthed at	by	11. Marital Status  1 Never Married 2 Married  3 Nover Married 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 Th If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify: B1	e, etc.
215-0036	hin 72 horas an "natur Medical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(G	cedent's Usual Occup- ive kind of work done of b. DO NOT use retired	during most of work	king	16b. Kind of Business/	Industry
2	12 should be filed within h and Mental Hygiene. 7 is marked other then "fraumatic event, the Me.	Ве Соп	8 17. Father's Name (First, Middle, Last			Cook	18. Mother's Nam	e (First, Middle, M	College Maiden Surname)	
Maryland	should band Ments s marked	To	Calvert Blaney 19a. Informant's Name/Relationship (	Type, Print)	19b. M	ailing Address (Street		T. Bundy	City or Town, State, 2	Zip Code)
	ges 1 and 2 it of Health at it item 27 is or other tra		Soretta White / D		20b. Place of Di	North Ful sposition (Name of crematory or other place		-	ore, Mary1	
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Survice Live	y)	1	morial Pk.	Ceme.	В	altimore, C. Jones	Maryland F/H, P.A.
a E	8 9 E 8 8	2 13	23a. Part1. Enter the disease, or com	plications that caused	the death. Do not				more, Mary	1and 21215 Approximate Interval Between
	Pnysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	~		ery Dise	A Sec		li li	Onset and Death
	2/68	Examiner	Sequentially list conditions, Tany, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a nonsequence of):					
68760,	rificate be end physiciar as the buri	Medical		d						
О. Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 0 0 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year
σ.	n requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause give	en in Part I.	23e. Did tob	oacco use contribute to	
Il Records,		Completed						24a. Was ar autops perform 1 Yes 2	y prior to d	atopsy findings available completion of cause of
of Vital	S 1	To Be	25. Was case referred to medical examiner?  1 □ Yes No	Hospital: Inpatie		tient 3 DOA Oth	er: 4 🗌 Nursing H		nce 6 Other (Spec	cify)
Division o	Jing After funel	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigatio  3 Suicide 6 Could not be	ια -		y Worl	y at k? Yes 2 □ No	28d. Describe ho		Courts Marsh
DİVİ	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		4 Homicide determined	building, et	c. (Specify)	street, factory, office		City or Town		
	To the Hospitel or within 24 hours after To the Funerel Dirticompletely filled in the	Medical	(Check only 2   Medical Exa	miner: On the basis o and manner st	f examination and/o ated.	r investigation, in my o	pinion, death occur	red at the time, da	ate and place, and due	to the cause(s)
)	S S S S S S S S S S S S S S S S S S S	2	29b. Signature and title of certifier	mo		D /	8547	/	9d. Date signed (Monti	AOUS
	7		30. Name and address of person who	law Mo	leath (Item 23a) (Ty	oe, Print)	ene St.	Balti	more, MD	
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	barle			Avg 28,	

Amend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

28370 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Kobert 0335 AM 08 Robert T. West 2005 26 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howar troward Count MD Dombia 8. Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1⊠M 2□F 212-16-8917 1921 Washington, D.C Director 84 Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28e-f show any njury or other traumatic event, the Medical Exart actimust be notified at once. 1 ☐ Yes 2√ No Director Laurel Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20723 10735 Crestview Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. þ 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Industrial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert M. West Mary A. Schrepler 2 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Helen West Price Touhey 8414 Church Lane Road Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 8/27/05 Hampstead, Maryland Carroll Cremation Sen <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final Priysician Schemic ardiomyopathy disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical CERTICAT the attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ racture 1 Yes 2 No 3 Probably 4 Unknown Completed 1)15000e 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an TOMAIN autopsy 2 No Thyroidism certificate 25. Was case referred to medical examiner? 1 ☐ Yes Division of Vital Hospital or Attanding Physicien: Be 26. Place of Death (Check only one) Hospital: Other: P 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral dir 28c. Injury at Work? ate of In ury onth, Jay Year) 27. Manner of Death 28a. 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending lejury 1 ☐ Yes 2 ☑ No 22 05 death. 900 4 a 2 Accident investigation Diractor: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Poute Number, City or Town, State) 10 7 35 CREST VIEW M 28e. Place o Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after ome 20723 aurel within 24 hours a MD 29a. Certifier 1 Certifying Physician: : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exam (Check only In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) To the 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of per n who co Olney, MD 20832 3414 Olandwood Cf 6 Bruce Knolmager MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 3 0 2005

		•	Tease 1	State of Maryland	d / Depa	artment of He ctificate of D	ealth and M	lental Hygie	ene 2005	2837
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
п	Physicia		Mary Franc	es Waskevich				AUGUST	21 2005	9:21 PM
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or I	Location of Death	11.51	4c. County of Deat	
	Examini	c.	SINAI HUSPITA		IMADYLE	-	IMOR	5	•	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.		9. Birt	hplace (State or Foreign
	Director		148-24-3780	M 2XF 87	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Oct. 29,	1917 Co	MD
-		i	Usual Residence of Decedent							
	ylan		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-fs	Director	MD Baltimor	e	Reiste	erstown				1 ☐ Yes 2X☐ No
	h the	ire	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	th wil	alD	115 Glyndon Driv	e, Apt. A2		211	.36		USA	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Modical Examiliant mat be notified at	Funeral		Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of His f Yes, specify Cuban	spanic Origin? (Sp.	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
ဖွ	or Ite	E.	1 Never Married 2 Married	1 ☐ Yes 2 No		1 ☐ Yes 2 █ No	Specify:	, , , , , ,	Specify:	a, 610.
ğ	ours ral',	d by	3 ☐ Widowed 4 🎇 Divorced	Year or Dates:					Wh	ite
2	72 h 'natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupation of work done di	uring most of work	ing 16	b. Kind of Business/	Industry
2	ithin Ber	lди	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)				
2	filed w Hygier other ti	S		5+		Ceacher			Education	n
Maryland 21215-0036	be fill d oth d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
$\frac{8}{3}$	should be ind Mental imarked c	٥	Arthur Francis Bar	Mark				iola Alle		
a	C1 (0 68		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	ig Address (Street al	nd Number or Rur	al Route Number, C	City or Town, State, 2	Zip Code)
	1 and 3 Health Iom 27 other tr		Christine L. Waske	vich Daughter	5 Ch	erry Tree				
Baltimore,	permit. Pages 1 am Department of Heali Important: if item 2 any mjury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Re		lace of Dispo emetery, cren	sition (Name of natory or other place		Date 20	c. Location - City or	Town, State
Ĕ	Pag nent ant: I		' 4 □ Donation 5 □ Other (Specify)	i _	roll (	Cremation	8/24	/05	Hampstead	, MD
a	permit. Departi Importi any inj		21. Signature of Fungral Service License	7.1	/ -   22	. Name and Address	s of Facility	11824	Reisterst	own Road
m	89889		Septien	m Janks	lus I	Eline Fune	ral Home	Reiste	erstown, M	ID 21136
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	cause on each line.  CORDN 6  Due to (or as a consequence to (or as a conseque	FRY sence of):	ART		DISE A		Approximate Interval Between Onset and Death  2 Days  3 Days
P.O. Box 68760,	Attending Physician: The law requires that the death certificate be executed in death.  If death.  Socior: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physiclan/Medical Examiner	resulting in death) Last	Due to (or as a consequence of pregnant at time of de 9 Dukhown	ncy death 3	Ectopic pregnancy			23d. Date of del Month	ivery Day Year
<u>Ч</u>	d by letack	Phy		shuting to death but not requ	iting in the u	adarhina anuna anun	n in Port I	23a Did tobar	co use contribute to	the cause of death?
rds,	w requires that been signed b should be deta	ed by	Part II. Dther significant conditions conf	nouting to death but not resu	illing in the ur	nderlying cause give	n in Part i.	1	2 No 3 Pr	
Vital Records,	he law re e has be ige 2 sho	Completed						24a. Was an autopsy performe	d) prior to death?	topsy findings available completion of cause of
a	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical				On Plane of Panel		No 1 ☐ Yes	2 <b>2</b> No
	sicia	o B	examiner?	ospital:	ER/Outpatien	t 3 DOA Other	~	n (Check only one)	e 6 □Other (Spec	.4.)
on of	ding Phys h. After this tuneral dii	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how		any)
Division of	Dir Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours atte To the Funeral Dir. completely tilled in 1	edicai C	29a. Certifier 1 Certifying Phys (Check only one)	cian: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or inv	n occurred at the time restigation, in my opi	e, date and place, inion, death occurr	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	o the ithin o the smple	Med	29b. Signature and title of certifier	-		29c. License	number	29d	. Date signed (Monti	n, Day, Year)
1	F 3 F 8		& Salala a	-on- K1		DAG	549			**
•			20 Name and office of the	LAJVA	020\ (T		541	טו וכ	8/21/2	005
	5		SYLVANUS D'		INAL	HOSPI	TAL	F BAI	- TIMOR	٤
	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 0 2	32. Registrar's Signat	ture	Cordi				

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2005 28372 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Year WILLIAMS JOELLEN 06;00AM /Medical Augusi 25 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CENTER HARBOR HOSPITAL BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1 □ M 2√2 F Months Days Hours Director 214-58-5473 May 21, 1952 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28e-f shov other treumetic event, the Modical Examiner must be politified at Director Maryland Anne Arundel 1 XYes 2 □ No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 179 Morris Court 21061 death v U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐xNo Specify: 3 Widowed 4 □ Divorced Specify Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Gas \* Electric Customer Service Rep 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Aaron Brewer ပ Ruby Bevel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n eny injury or other treun Hurdisean Brewer Sister 2734 Harlem Avenue Baltimore, Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 Other (Specify) 08/30/05 Windsor Mill, Md. King Memorial Park 21. Signal re Funeral Service Licens e 22. Name and Address of Facility Estep Brothers Funeral Service 1300 Eutaw Place, Baltimore, Md. 21217 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE RESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEVERE ANOXIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner transit ADRENAL INSUFFICIENCY that initiated events resulting in death) Last burial-Due to (or as a consequence of) Box 68760. physician Physician/Medical CHRONIC RENAL FAILURE the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9□ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ The law requires pe RENAL Completed FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ 24b. Were autopsy findings available prior to completion of cause of death? has CANCER BREAST METASTATIC certificate Division of Vital 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No this ( 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending after death.

I Director: Af
d in by the fu investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funerel I

completely filled To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 25, 2005 ADJEI RES 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABBUL APIEI 3001 SOUTH HAND VER STREET, MARYLAND BALTIMORE 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28373 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 23, 2005 Eunice R. Washington 7:40AMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton, Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Days Year) 0 2 7 5 0 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2√2F 5.5 Yrs. Maryland Director 217-60-6482 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b Counts 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23e or 28a-f show other treumatic event, the Medical Examinar must be notified at Maryland Prince Georges
100. Street and Number
9105 Cheltenham Drive Brandywine 1 XYes 2 No 10f. Zip Code 10g, Citizen of What Country? 9105 Cheltenham Drive 20613 USA death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other then "naturel" or hard any injury or other treumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerome Washington Ruby Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Strickland/Daughter 9105 Cheltenham Drive, Brandywine, Md 20613 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Trinity Cemetary 1 

Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) 08/29/05 Waldorf, Maryland 22. Name and Address of Facility Adams Funeral Home, Aquasco, Maryland Approxi 20508 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one-caus hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician come with /Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Entail of Carring Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? e Hospitel or Attending Pl 24 hours after death. e Funerel Director; After the 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2005 Registrar

	1 3	<b>,</b> ,
20	al Hygiene no E	State of Maryland / Department of Health and
40	Reg. No.	State of Maryland / Department of Health and Certificate of Death

			1 - For State Registrar	otato oi mo	a. y tarra	Cei	rtificat	te of i			F	Reg. No.	005	2831	4
	Dhysiai		1. Decedent's Name (First, Midd	ile, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death	
	Physici /Medi			Daniel	Thoma	s Wis	ssing	er			August		2005	2234 P	М
	Examir		4a. Facility Name (If not institution	on, give street and number)			4b. City.	Town, or	r Location	of Death			County of Death		
d			6607 McCahill				Laur					Pr	ince Ge	orge's	
	Funeral Director		5. Social Security Number 213-17-0155	1MM 2005	9 (In yrs. las	t birthday) Yrs.	If Unde Months	r 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day Feb 25	v, Year)	Col	place (State or Forei Intry) hington, D(	_
	pue *		Usual Residence of Decedent  10a. State 10b. Count	v	10c. City, 1	Town or Lo	cation							10d. Inside City Limit	te
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Items 23a or 28a-f ehow enypriquity or other traumatic event, I'na Medical Examinar must be notified at ances.	Director	MD Prin	ce George	Laur									1 □ Yes 2 [X]N	
	vith th	2	10e. Street and Number				10f. Zig	Code				10g. Citiz	en of What Cor	intry?	
	ath v		6607 McCahill					707					S.A.		
	Item Item	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Ma	12. Was Decedent E Armed Forces? rried 1 ☐ Yes 2 ☒ N	ever in U.S.	13. 1	vvas Dece If Yes, spe	cify Cuba	ispanic O in, Mexica	rigin? (Spe in, Puerto	ecify Yes or No- Rican, etc.)	' '	<ol> <li>Race - Amer Black, White</li> </ol>		
1215-0036	ral', or	þ	3 ☐ Widowed 4 ☐ Divorce	If Yes Give	10		1 🗆 Yes	2 <b>₺</b> No	Specify	<i>i</i> :			Specify: Whi	te	
ה ה	72 hc	Completed	15. Decede (Specify only high	nt's Education est grade completed)	1	6a. Deced	dent's Usu kind of wo	al Occupa	ation du <i>ring</i> mo	st of work	ng	16b. Kin	d of Business/I	ndustry	
7	within ne.	ldm	Elementary/Secondary (0-12)	College (1-4or 5								Hear	Daniel		
N	Hygie ther nt, II		12 17. Father's Name (First, Middle	Last)		Appre	ntice	e Med			(First, Middle,		y Equi	Silient	
and	d be	To Be	Robert Wissing								Riley	marderi	oumaine)		
چ	shound Mind Mind Mind Mind	-	19a. Informant's Name/Relation			19b. Mailir	ng Address	s (Street a			I Route Numbe	r, City or	Town, State, Z	ip Code)	
Z	nd 2 allth a 27 io		Sarah Wissinge	r /sister							Laurel,				
ē,	s 1 a f Hea ltern othe	1 8	20a. Method of Disposition		20b. Plac	e of Dispo etery, cren					ate		ation - City or T		
Baitimor	Page nent country or	: (	1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (							Aug 2	7, 05	Laur	el, Mar	vland	
a	permit. Departn Imports eny inju		21. Signature of Funeral Service	License							Home, P.		•		
_	20E 2 9		Now H	100	M0077	3 3	13 Ta	albot	t Av	e. La	aurel, N	Maryl	and 20	707-4389	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that caused t only one cause on each lin	the death. I	Do not ent	er the mod	de of dyin	g, such as	s cardiac o	r respiratory ari	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Contact	- sho	taun	wo.	nd.	d of	oad				Onset and Death	
	/Medical Examiner		resulting in dealing	Due to (or as a	consequen	ice of):									
		er	Sequentially list conditions,	b. Oue to for as a	s eor secuen	isa of/.									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>\</b>											
֖֖֝֝֝֝֝ ׆	exec en an rial-tr		resulting in death) Last	c. Due to (or as a	consequen	ice of);									
00/00	icate be executed physicien and s the burial-transit	Medical		d.									_		
o XO	certif Iding	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			]Ectopic p	regnancy			- 12	23	3d. Date of deliv		
	The law requires that the death cer ate hes been signed by the attendir page 2 should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 1 9□Unknown			Other (sp						Month	Day Year	
'n.	ss that gned to	by P	Part II. Other significant condit	ions contributing to death bu	it not resultir	ng in the ur	nderlying o	ause give	en in Part	I.	23e. Did to	bacco us	e contribute to	he cause of death?	
spiosa	equire en sig								-	-	1 🗆 Y	es 25	LNo 3□Pro	bably 4 □Unknow	n
ວັ	lawr les be	Completed									24a. Was a		24b. Were aut	opsy findings available	le
=	: The cate h	Co		414							perform DE Yes	med? 2 □ No	death?	2 □ No	
VII	ilcian certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe	_		Check only or			-+	
5	Phys r this sral di	i: To	1 Yes 2 No 27. Manner of Death	1 Inpatier	v 28	Outpatien b. Time of		74	4 🗆 🛚 1		ne 5 ☐ Reside 28d. Describe he			ny) at scene	<u> </u>
VISIOI	nding th. :: Afte e fune	Certification;	1 □Natural 5 □ Pendi	ing For (Month, Day	Year) Fo.	Injury	рм	28c. Injury Work 1 □ 1	(? Yes 2 (2				st self		
<u> </u>	Atter r dea ector by the	Ifica	3 Suicide 6 ☐ Could	not be 28e. Place of Inju	ry - At home						28f. Location (S	treet and		al Route Number,	
5	tal or rs afte al Dir ed in	Cert	4 - Homolde	building, etc.	home					(	6607 N	n, State)	Will Dr,	Laurel, Mil	>
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: Attent his certificate hes completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physicien: To the best of Exeminer: On the basis of and manner stat	examination	dge, death and/or inv	occurred estigation	at the tim , in my op	e, date a	nd place, a ath occurre	and due to the c ed at the time, d	ause(s) a ate and p	and manner as solace, and due to	stated. o the cause(s)	
	To the within to the comp	ž	29b. Signature and title of certific	er .			290	. License	number		2	9d. Date	signed (Month,	Day, Year)	
	10.00.00		Touslos		red			C.M	I.E.		A	ugus	t 21, 2	005	
	1		30. Name and address of per		eath (Item 23	Ba) (Type, I	Print) nn St	reet	. Ba	ltimo	re, Mar	ylan	d 21201		
	Sta	te	Tasha LGV & 31. Date filed (Month, Day, Year	) 32 Registra	r's Signature	• • • • • • • • • • • • • • • • • • •			,						
	Registr		AUG 3 0 2	005	K	Acres 6									
DHN	/H 17 Rev 1/20	001		1000000	1	1000									The same
						ODIGIN	LAI								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year WEBER Month **Physician** 4:59A M August Leonara 27 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner V4 MedicaL BALL: nuRe Conter NIA Himure If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Nov. 22,1925 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours **X**XM 2□ F 79 Boston, Director 031-12-7877 Nov. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event. It's Midical Examinar mast by notified at 1 ☐ Yes 2 No Director Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 Camberley Circle 21204 Apt.5C United States Be Completed by Funeral 12. Was Decedent Ever in U.S.
Ammed Forces?
1 (2)Yes 2 Norean
If Yes, Give Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Korean Year or Date Conflict 1 ☐ Yes 2 🛣 No White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Race Horse Trainer 12 02 Horse Racing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be in nent of Heelth and Mental I William Charles VonWeber Louise Herming d'Eicher ၟႄ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2: Department of Heelth at Important: If item 27 is any injury or other trau 730 Camberley Circle Apt.5C Towson, MD. 21204 Mrs.Irmgard Else Von Weber(wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Aug. 28, 2005 Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility at ives Funeral & Cremation Ctr.P.A. 25 York Road Timonium, Maryland 21093 23a. Part. In it the fue ase, or complicative that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Potention Sequentially list conditions, if any learing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ORI NAR use as the burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 signed by the attending physicien Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Year for in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy performed? 1 Yes 2 No 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 1\_Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Infury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident efter death filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (ftem 23a) (Type, Pnnt) Street Baltinuce, MD 21201 MD OShio INO 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 5 nmet /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner tora If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 100 M 2□ F Days Yrs. Director nia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director orest 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 1630 21050 iche by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify: White 3 Widowed 4 Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) oreman permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ite vens 19a. Informant's Name/Relationship (Type, P int) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) orest 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) ia Gardens 22. Name and Address of Facility 21. Signatury of Funeral Service Licenses FOREST HILL EVANS FUNERIAL CHAPEL-BELAIR 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** DEM EN TIA /Medical Due to (or as a consequence of) Examiner ATHEROS CLEROSIS 34%. Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) COPD Due to (or as a consequence of) Box 68760. Physician/Medical use as I 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 1 Yes Division of Vital To the Hospital or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 1 🗹 Inpatient 2 ER/Outpatient 2 1 Yes 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury s after death. 27. Manner of Death 28d. Describe how injury occurred Certification; Injury at Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 41080 era 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1208 Churchville Rd., Ste. 201, Bel Air, MD Sood, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

				For State Registrar	State o	f Marylar	nd / Depa <i>Cer</i>	artment of H	lealth and Death	d Mental Hy	/giene 0	05	28377
		Physicia		1. Decedent's Name (First, Middle, L Jane	Glady	s	Wetmor			2. Date of De Month Augus	eath Day		3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, g. Doctor's Hosp:	ive street and num Ltal - L	<sub>mber)</sub> anham		4b. City, Town, or Lanhan			4c. County	of Death	rge's
		uneral Director		289-26-3929	Sex 1 □ M 2 □XF	7. Age (In yrs. 93	. last birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, D. Nov. 1	7, 1911	9. Birthplace Country Whate	e (State or Foreign
21	vith the Maryland	or 28a-f ahow be notified at	Funeral Director	10e. Street and Number	George'		ity, Town or Lo	10f. Zip Code			10g. Citizen of V		Inside City Limits  1 ☐ Yes 2 ☐ No  X
re, Jan	21215-0036 within 72 hours after death	and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f ahow aumatic evant, the Mcdical Examinar must be notified at	Completed by Funeral	6300 Galaxy Coun  11. Marital Status  1 Never Married 2 Married  3 Xwidowed 4 Divorced  15. Decedent's (Specify only highest g	12. Was Dece Armed Fo 1  Yes If Yes, Gin Year or D Education rade completed)	2 XNo ve ates:	16a. Deced	20715  Was Decedent of H f Yes, specify Cuba  I Yes 2 No X  dent's Usual Occup kind of work done 20 NOT use retired	lispanic Origin? an, Mexican, Pi Specify: sation during most of	? (Specify Yes or Nuerto Rican, etc.)	O- 14. Rac Blac Specify	e - American ck, White, etc v: Whi	te
+more,	nd 212	ai Hygiene. I othar thar Ivant, the N	Be Com	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last	College (*2	1-4or 5+)	Sch	nool Teac		Name (First, Middle	Element , Maiden Suman		ehoo1
Wet	Maryland		P.	John Smiarowski  19a. Informant's Name/Relationship Audrey L. Pickup		nter			and Number o	ania Hoyn Rural Route Numb Bowie, M	oer, City or Town,	State, Zip Co	ode)
0	(i) (ii)	ent of Realth nt: If item 27 ry or other tr		20a. Method of Disposition  1   Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Special Control of the Contro	☐Removal from	20b. State	Place of Dispo cemetery, cren	sition (Name of natory or other place Lslaws Ce	ce)	Date -2-05	20c. Location -		
	Baltil	Department of Interpreted Inte	l l	21. Signature of Funeral Service Lid		20	22 W	Name and Addre	ss of Facility uneral				-
•	Ex.	hysicia the bur	edical Examiner	23a. Part   Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijmy that initiated events resulting in death) Last	a	s a conference of a conference of a conference of a conservation o	quence of):	Ruph	, such as can	diac or respiratory a	arrest,	In	pproximate terval Batween inset and Death
	P.O. Box (	ed by the attending p detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 ∏ Fet nant at time of	at death 3	Ectopic pregnancy Other (specify)	/	-	23d. Dat Mo	te of delivery nth Da	ay Year
		is certilicete has been signed by director, page 2 should be detac	e Completed by Ph	Part II. Other significant conditions Temporal Temporal 25. Was case referred to medical	contributing to d	,	sulting in the ur	nderlying cause giv		1 □ 24a, Was auto perf 1 □ Yes	s an 24b. Voormed?	3 Probab	y findings available letion of cause of
	Division of Vital Records,	fter th	Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 No Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not determine	28a. Date (Mon	of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Wor	er: 4 □ Nursin v at	28f. Location		red	loute Number,
•	To the Hospital	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex.  29b. Signature on title of certifier	aminer: On the b	e best of my kn asis of examin ner stated.	nowledge, death	vestigation, in my o	pinion, death o	lace, and due to the courred at the time	, date and place,	and due to th	e cause(s)
	1	Sta Registr		30. Name and address of person when y 3 CC, ( 31. Date filed (Month, Day, Year)	CACCA 32. F	se of death (Ite	e X	Print) DP/N	DEK 3	U Bec	e ~1.	20	715

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Webster August 25, 2005 9:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X** M 2□ F Yrs. Director 1932 West Virginia 236-48-8952 Usual Residence of Decedent with the Maryland 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1418 Clearview Road 21040 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. snt: If item 27 Is marked other then "naturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Mes 2 No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Fire Chief U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lilly Joseph Basil Wills Lena Joyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent: If item 27 Is any injury or other treuonce. 1418 Clearview Road, Edgewood, Maryland 21040 Goldie M. Wills - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 8/29/05 Bel Air, Maryland 21. Signatur Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Finysician relegenows mi /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 1 ☐ Yes 2 № No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) within 24 hours a To the Funeral C TO Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.1) lain 08-26-2005 D45530 30. Name and address of person who completed cause of death (Item 23a) (Type, Print),
5. SIVASAILAM, SUITE 200, S. ATWOOD ROAD BELAIR MD 21014 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2005 Registrar

Wills, Basil

State of Maryland / Department of Health and Mental Hygiene 2005 1 - State Registrar 28379 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Edward Franklin Welch 20 0210A Aug 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Memorial Hopsital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec 26, 1931

8. Birthplace (State or Foreign Country)
Washington DC Birthplace (State or Foreign Country) XXX 2 F 217 28 8438 Director 73 Yrs Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~~~~ any injury or other traumatic average. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Calvert Maryland Lusby 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Appeal Lane 20675 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes ZYNo If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0wner Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Weltsch Lillian Yuran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rolph Welch (Son) P.O. Box 4 , Aquasco , MD 20608 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ② Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 ☐ Other (Specify) Lee Crematory Aug 21, 2005 Clinton, Maryland 21. Signature of Funeral Sprivic Live ee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Rd, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Respi disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate the list of January Cause (Disease or injury that initiated events resulting in death) Last Ren Examiner Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed dui attending physician and CAULE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the ! IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ №6 1 ☐ Impatient 2 ☐ ER/Outpatient this 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shel D 50290 8-20-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pring Dhi vey 110, HOSP Frederica 20678 32. Fran's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 Registrar

			1. Decedent's Name (First, Middle,				rtment of ME, C85 rtificate of		2. Date of De	ath		3. Time of Death
	Physici /Medic		Callie A. Will:	Lams					AUGUS	T 26	2005	3:21 PM
	Examin		4a. Facility Name (If not institution, SAINT AGNEC	give street and nu	_			or Location of De		4c. Cou	unty of Death	
*	Funeral Director		5. Social Security Number 225-22-0326	5. Sex 1 □ M 2 ☑ F	7. Age (/ 80	In yrs. last birthday) Yrs.	If Under 1 Yea Months Days			th ay, Year) 25	9. Birtho Coun Virgi	lace (State or Foreign itry) inia
	aryland ehow	ō	Usual Residence of Decedent  10a. State 10b. County  MD N/A			Oc. City, Town or Lo	cation				11	0d. fnside City Limits 1 ☐ Yes 2 ☐ No
	vith the Ma or 28a-f	Director	10e. Street and Number 2645 Northshire	Dedago			10f. Zip Code				of What Coun	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or items 23s or 28s-f show event, the Medical Examinar moust be notified at	Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Dec Armed Fo	orces?		21230 Was Decedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	U.S.A	• Race - Americ Black, White, e	
-0036	hours aft	by	3XXWidowed 4 ☐ Divorced	If Yes, Gi Year or D	Ve		1 ☐ Yes 2 ☐ No				ecify: Whi	
1215	within 72 l ene. then "nat	Completed	(Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	(Give	kind of work don DO NOT use retir	during most of v	vorking	Ownl		addity
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla Fleatht and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-1 ehov other traumatic event, the Medical Exemination matter confiled at	To Be Co	17. Father's Name (First, Middle, L Harvie Lee Clark			Tromoni			lame (First, Middle Bell Gale	, Maiden Sun		
Mary	nd 2 shou lith and M 27 is mar r traumat	-	19a. Informant's Name/Relationsh Charles H. Willi				_		Rural Route Numb e Baltimo			Code)
Baltimore,	Pages 1 and 2 nent of Health a nt: if item 27 is iry or other tra		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation  4 ☐ Denation 5 ☐ Other (Sp			20b. Place of Dispo cemetery, cree Cedar Hi	natory or other pl		Date 9-2005		on · City or To	
Balti	permit. Pages Department of h Important: If Ite any injury or of		21. Sign to e of Funeral Service L	-	VOID	Rell AT	Name and Add nbrose Fi 19 Hamm	ress of Facility Inera <u>1</u> Honds Fer	ome of La ry Rd. La			
e	Physician		23a. Part1. Enter the disease, or or shock, or heart failure. List of Immediate Cause (Final disease or condition	_		e death. Do not ent	er the mode of dy	ing, such as card	iac or respiratory a	rrest,	4	Approximate Interval Between Onset and Death
76 / 18	/Medical Examiner	r	resulting in death)	Due to	(or as a c	consequence of):					4	DAYS-
A CK Due 8760,	sate be executed obysicien and the burial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	n	FEC	consequence of):	P WOU	NO .	PPROVED BY MEDIC	A FORM	+	MENOUR
16- €. O. Box 68		Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		oirth 2 [ nant at tim	Fetaf death 3	Ectopic pregnan	V	30)		Date of deliver Month	ry Day Year
CA rds, P	requires that been signed by hould be deta	d by P	Part II. Other significant condition	BRILL	eath but r	not resulting in the u	nderlying cause g	iven in Part I.		obacco use c Yes 2 □ No		e cause of death?
\M\S Reco	The law requiriete has been sipage 2 should I	omplete	Hip fracture; Hyp		e At	heroscler	otic Can	diovas-		an 24 osy ormed?	b. Were autor prior to con death?	osy findings available npfetion of cause of
-L-1+ Vital	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	_		10	hor	1 ☐ Yes eath <i>Check only c</i>	one)	1 🗆 Yes	
	g Phys er this eral di	n: To	27. Manner of Death	28a. Date (Mon			1 3L DOA	4 🗀 Nursing	Home 5 Resident			")
Division	To the Hospital or Attending Phwithin 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	Certification:	5 Pending 2 Accident investigat 3 Suicide 6 Could no determin	tion Unkn	own	Unknow	<b>n</b> M 10	Yes 2 No	Probab	Street and Nu		l Route Number.
آم	Hospital or Att		29a. Certifier 1 Certifying	Physician: To the	best of n	- At home, farm, str Specify) ny knowledge, deatl	occurred at the	me date and pla	City or Tow Unknow	n cause(s) and	manner as sta	ated.
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical E	xaminer: On the b	asis of ex ner stated	amination and/or in	vestigation, in my	opinion, death oc	curred at the time,	date and place 29d. Date sign	ned (Month, L	the cause(s)  Day, Year)
	est o		1 Sup	le		M·D	PI	86 16		Augus-	T 26	2005. ND-21219
	-		30. Name and address of person w	ho completed cau:	se of deat	n (ttem 23a) (Type,	Print)					. 10 0

			1 - For State of Maryland / Departm	ent of Health and Menta	Reg. No. 2005 283	8 I
	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last)  CHARLES SHELLY WELCH	2. Date Mor Aut City, Town, or Location of Death	te of Death nth Day Year 3. Time of Dea	th { M
	Examir Funeral Director	ier	BACTIMICUS USTGEATUS ADMINISTRATION MEDICALO		27/2	reign
	ith the Maryland or 28e-1 show	Director	10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMOR 10e. Street and Number 10d.		10d. Inside City Ling 1 10g. Citizen of What Country?	
215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-1 show ha Moulcal Examiliar", ust boundilited at	Completed by Funeral	1219 BROENING HIGHWAY  11. Marital Status 1 Never Married 2 Married	21224 ecedent of Hispanic Origin? (Specify Yes specify Cuban, Mexican, Puerto Rican, et as 2X No Specify:  Usual Occupation of work done during most of working of the specified)	U.S.A.  Is or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE  16b. Kind of Business/Industry	
Maryland 21215-0036	be filed ttal Hygind other event, II	To Be Com	17. Father's Name (First, Middle, Last)  CHARLES E. WELCH	ENANCE 18. Mother's Name (First, I) CATHERINE	N/A	
	es 1 and 2 s of Health ar fitem 27 is r other trau		KAREN ZIELINSKI/ DAUGHTER 1219 B  20a. Method of Disposition  1 Survey Burgle 2 Cremation 3 Removal from State	ROENING HIGHWAY	20c. Location - City or Town, State	4
Baltimore,	permit. Pag Department Important: i any injury o once.		21. Signature of Funaval Service Licensee		OWINGS MILLS,MD. FUNERAL HOME ,BALTIMORE,MD. 212:	2 4
8760, <	be executed be executed by Medical Example of attending physician and as the burial-transit for use as the burial-transit	edical Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	HROMBO (MBCL)	atory arrest, Approximate Interval Between Onset and Death	1
.O. Box 68	at the death certificate by the attending phys tached for use as the	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	ic pregnancy (specify)	23d. Date of delivery Month Day Year	
<u>α</u>	requires thaten signed hould be de	by	Part II. Other significent conditions contributing to death out not resulting in the underlying		e. Did tobacco use contribute to the cause of death	own
Vital Records,	Physician: The law this certificate has b ral director, page 2 sl	Be Completed	25. Was case referred to medical examiner?	1 ☐ 26. Place of Death (Check	a. Was an autopsy findings availation of cause prior to completion of cause death?  Yes 2□ No  1□ Yes 2□ No	able of
Division of	ing After une	Certification; To	112 Inpatient 2 ENOutpatient 3		☐ Residence 6 ☐ Other (Specify) scribe how injury occurred	
Divi	in life			City	ation (Street and Number or Rural Route Number, y or Town, State) to the cause(s) and manner as stated.	
<b>}</b>	1	Medical	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	-
	3+1 Sta Registr		30. Name and addr ss of person who empleted cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  AUG 3 0 2005	22 S, GREENES	AUGUST 26 2005 T BAUTMORE, MARYLA	400

			For State	State of Mary	land / Depa	artment of H	Health and	Mental Hyg	iene 200	5 28382
			Registrar     Decedent's Name (First, Middle,	Last)				2. Date of Deat		3. Time of Death
	Physici		DAVID THOMAS ZE	BRON SR				August	27 200	ar 4:15 PM
	/Medio		4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Deat		4c. County of D	
			St. Arnes	Healthcare	,	Balt	more			
	- Funeral		5. Social Security Number		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9.	Birthplace (State or Foreign Country)
¥	<ul> <li>Director</li> </ul>		220.66.6637	1 M 2 F	50 Yrs.			FEB 3,		MD
	land		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 sh	ţō	MD ANNE	ARUNDEL	LINTHICUN					1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	ARUNDEL	TINITICOL	10f. Zip Code		1	0g. Citizen of Wha	
	death with the Maryland ms 23s or 28s-f show rmatter notified at		512 SUDBURY RD.			21090	)		USA	
		Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of H	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.
20	hours after tural', or ite	by Fu	1 Never Married XX Marrie	If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Specify:	
2-0036	fural'		3 Widowed 4 Divorced	Year or Dates:	162 Doco	XX dent's Usual Occus	nation		16b. Kind of Busine	WHITE
ည်	within 72 ene. than "na	ojet	15. Decedent's (Specify only highest	grade completed)	(Give	kind of work done  DO NOT use retire	during most of wo	rking	700. Killa of Basilli	sas/industry
7[7	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		SUPERVI			BGE	
ַ	Hyg Hyg ant,	0	17. Father's Name (First, Middle, L	ast)		001 2311 7		me (First, Middle, i		
land	uld be Aental rked c	ToB	FRANK ZEBRON				CECILIA	KOZLOWSI	ΧI	
Mary	d 2 shoul th and M ?7 is mark traumati		19a. Informant's Name/Relationsh			,			, City or Town, Sta	e, Zip Code)
_	s 1 and 3 if Health item 27 other tra		NANCY ZEBRON	WIFE			RD LINTH	ICUM, MD		
more,	Pages 1 nent of H int: If ite		20a. Method of Disposition  XX Burial 2 ☐ Cremation	ŀ	20b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State
Ē	Pages Iment of tent: If it		4 □ Donation 5 □ Other (Sp	ecify)	MEADOWRID		CANADA SERVICE AND AND AND ASSESSMENT OF THE PARTY OF THE		LKRIDGE,	MD
galti	permit. I Departm Importer any inju		21. Signature of Funeral Service L	1	EÏ	NAME and Addre	AL HOME,	P.A.		
	0.07.40		K. GREGOR						E, MD 210	D61 Approximate
			shock, or leart failure List	only one cause on each line.						Interval Between Onset and Death
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	- a. Atheros		-il Car	divusc	ulor D	rsease	10 years
	Examiner			Due to (or as a co	onsequence of):					,
		E.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							III
ĵ	exec en an		resulting in death) Last	Due to (or as a co	onsequence of):					
09/	cate be executed obysicien and the burial-transit	dical		d						
9	ntifica ng ph	Med	IF FEMALE:							<u> </u>
X Q R	leath certific attending p I for use as	lan/Me	23b. Was decedent pregnant	23c. If yes, outcome of p 1 Live birth 2 □		∃Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
	e dea he at hed fo	O	in the past 12 months?	4□Pregnant at tim 9□ Unknown	e of death 5[	Other (specify)	-		Month	Day 19ai
J.	The law requires thet the death certificate be executed the as been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Completed by Physi	9 ☐ Unknown  Part II. Other significant condition		of regulting in the	inderhine econo	von in Post I	220 Did to	hacco usa contribut	e to the cause of death?
Ś	w requires that been signed E should be delt	by	11 0	N C/S	or resuming in the u	inderlying cause gr	ven in Part I.	1 🗆 Ye	<b>.</b>	Probably 4 Unknown
Ö	requi	etec	-1191.000	717 12						
Hecords,	elaw hast je 2 s	m pi						24a. Was a autops perform	sy prior	autopsy findings available to completion of cause of
ᇹ			1.11					1 ☐ Yes	2 <b>X</b> No 1□	Yes 2□ No
Vital	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:	a Menia	Otl	hor	ath Check only on	- Contract of the Contract of	
ö	> .00	): To	1 ∑XYes 2 ☐ No 27. Manner of Death	28a. Date of Injury	2 KER/Outpatier 28b. Time o	N 3LI DOA	4   Nursing i		ence 6 Other (	Specify)
0	ding th. Afte fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Day Ye	ear) Injury		rk? ]Yes 2 □No			
Division of	Atten r dea octor	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of Injury	- At home, farm, sti	reet, factory, office		28f. Location (Si	treet and Number o	r Rural Route Number,
á	alor s afte il Dire	Certification;	4  Homicide	building, etc. (	opecity)			City or Town	n, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.			Physicien: To the best of m						
	in 24 in 24 ine Fu	Medical	one)	xeminer: On the basis of ex and manner stated	annitation and/or in					
	To t To t	Σ	29b. Signature and this of certifier	1/2 1		29c. Licen	se number	1	9d. Date signed (M	
	1		1 (1-1)	1001	MD	D	00 11)	13	tugust.	21, 2005
	10		30. Name and address of person v	ng completed cause of death	(Item 23a) (Type,	Print)	1	Hoyer	1 7	17, 2005
		7 2	31. Date filed (Month, Day, Year)	den Detr	M M V)	10.1	tgnes	116) p: 7	01 / 13/	14 more
100	Sta Regist		,	21	Le	And.	1	/	•	
8	ricgist	reit	AUG	3 0 2005 Fier	yes St.	MOBREL				

) ) (	<i>31</i>		1 - For State Registrar	tate of Maryland	d / Depa <i>Cer</i>	rtment of H	ealth and Death	Mental Hyç	giene 20	05 28383
	* Dhuaisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physici /Medic		Charles Stanl		on			August		005 2006 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give stree			4b. City, Town, or	-	th	4c. County of	
.5			Prince George's Hos  5. Social Security Number 6. Sex	7. Age (In yrs. Ia		Cheve		S. B. Date of Birth		ce George's
	Funeral Director	9	577-98-8986 1 <sup>1</sup> X <sup>M</sup>		Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day 02/02/	7, Year) 1976	9. Birthplace (State or Foreign Country) Washington, DC
	ס		Usual Residence of Decedent							
	show	_	10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M 28a-f	ecto	MD PG  10e. Street and Number	Lk	andove	10f. Zip Code			10g. Citizen of Wh	
	with	급	2500 Pine Brook Lane	≥ #105		2074	13			.S.A.
	ne 23	era	11. Marital Status 12. 1	Was Decedent Ever in U.S	3. 13. <u>V</u>	Vas Decedent of Hi	spanic Origin? (	Specify Yes or No-	14. Race	- American Indian,
9	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exercites must be notified at	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1		fYes, specify Cubai I□Yes 2√ No	n, мехісап, Рие Specify:	no Hican, etc.)	Specify:	, White, etc.
8	ural',		3 Widowed 4 Divorced	Year or Dates:						DIACK
5	"nat	lete	15. Decedent's Education (Specify only highest grade co		16a. Deced (Give	lent's Usual Occupa kind of work done a DO NOT use retired,	ition <i>furing</i> most of wo	orking	16b. Kind of Bus	iness/Industry
12	within iene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ician			Self	
P	e filed al Hygie other vent, II	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame	)
ylar	2 should be and Mental is marked c	To	Richard Anderson					ed Butle		
Maryland 21215-0036	12 sho		19a. Informant's Name/Relationship (Type, Mildred Banks – Mott			g Address (Street a			-	
d)	1 and Health em 27 Ither to		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of		Date		City or Town, State
п	ages int of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	metery, cren	natory or other place lemorial F		13/2005		r, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licensee	, sair		. Name and Addres	s of Facility	oman Flanor	al Contion	c, maryrand
ä	Depa Impo any I		Kendantire	enan)	P	.O. Box 416	: Suitla	nd. Marvlar	nd 20752	<b>5</b>
			23a. Part1 Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the death. ause on each line.	. Do not ente	er the mode of dying	g, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between
Ass.	Physician		Immediate Cause (Final disease or condition	CONTACT GUN		MOUND		LEAD		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
	uted d ansit	Examiner	Cause (Disease or injury							
oʻ	an an rial-tr		resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical	d							
¥ 6	leath certifica attending ph d for use as th	Med	IF FEMALE:	14						
Вох	attend for us	lan/	in the past 12 months?	If yes, outcome of pregnan 1□Live birth 2□Fetal of 4□Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
Ö	that the de ad by the detached	ysk		9 Unknown		Cities (specify)				
S, P		by Pt	Part II. Dther significant conditions contrib	uting to death but not resul	Iting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
rds	w requires been sign should be							1 🗆 Y	es 2 No 3	3 ☐ Probably 4 ☐ Unknown
of Vital Record	a w	Completed						24a. Was autop		ere autopsy findings available for to completion of cause of
Ä	The ate h page	Com						perfor	med? de	ath? XYes 2 □ No
/ita	sician: certific rector,	Be	25. Was case referred to medical examiner?			100		eath (Check only or	пе)	
of	Phys this al di	2	1XXYes 2 □ No Hosp 27. Manner of Death 2	1 Inpatient 2KJE	P/Outpatien 28b. Time of		4 🗆 Harising	Home 5 Resid	lence 6 Other	
	After	tlon	1 □Natural 5 □ Pending	(Month, Day Year)	injury OVID 1,25	Work	res 2 No		T SYLOT	_
Division	l or Attending efter death. Director: After I in by the fune	ertiflcation:		8e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office	э-	28f. Location (S	Street and Number	r or Rural Route Number,
Ö	s effer s effer al Dire	Cert	4 Homicide	RESIDED	SE			2500 PIKE		ANDOVEK, FLD
	Hospital or , 24 hours efter , Funeral Dire	edical (	(Check only 2 Medical Exeminer:	en: To the best of my know On the basis of examination	vledge, death	occurred at the tim	e, date and place	e, and due to the coursed at the time	cause(s) and man	ner as stated.
	# i # de	Med	one)	and manner stated.		29c. License				(Month, Day, Year)
<b>\</b>	with To		29b. Signature and title of certifier	£		OCIA		1		
1	)		30. Name and address of person who comp	leted cause of death (Item	23a) (Type		Ľı		August,	9, 2005
X	A		AM RUGO	, MD	, (-, po,					
	Sta	. 7	31. Date filed (Month, Day, Year)	37 Registrar's Signatu	ure-					
	Registi	rar	AUG 1 6 2005	Down A	April					

State of Maryland / Department of Health and Mental Hygien 2005 28384 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08/10/2005 АМ 4:30 Claudia Alvarez /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Glenn Dale 6300 Woodpoint Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 02/26/1925) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 80 Costa Rica Director 090-38-0272 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Prince Georges Glenn Dale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6300 Woodpoint Drive 20670 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Costa Rican Baltimore, Maryland 21215-0036 Specify: White 1 X Yes 2 □ No by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 6 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be need to the second be seen to the second be second be seen to the second be seen to the second be seen to th and Mental Juana Barboza Belarmino Solis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Nuria A. Grant/ Daughter 4713 Silverbrook Way Bowie, MD 20720 20b. Place of Disposition (Name of cemetary, crematory or other place)
Lakemont 20c. Location - City or Town, State 20a. Method of Disposition 10 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 08/12/2005 | Davidsonville, MD <sup>¹</sup> 4 □Donation 5 □ Other (Specify) <u>Memorial Gardens</u> 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 101-FKm 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final R **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed rattending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Hince An indel 2901 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 X No 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient Medical Certification: To 1 Tes 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) (Ah us 20706 9 AMMONOG 121 (Lidual AUG 1 2 2005 32. Registrar's Signature 31. Date filed (Month, State Registrar

		-	For State Registrar	State of M	laryland	d / Depa <i>Cei</i>	artment of H	ealth and Death	Mental Hyg	giene 0	05	28385
	Dhysiois	_	1. Decedent's Name (First, Middle, Las	1)					2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic	al	James Theod		cree,	Sr.			Aug.		2005	11:30 A M
	Examin	er	4a. Facility Name (If not institution, give		7)		4b. City, Town, or		th	4c. County		
			6652 Laurel Gr		/lm res 1	ast birthday)	Dentor		Data of Sirt		oline	lace (State or Foreign
	Funeral		5. Social Security Number 6. Se	W. 1000	.ge ( <i>III yrs. II</i>	Yrs.	Months Days	Hours Min	(Month, Day	Year)	Coun	try)
	Director	-	216-40-2690 Usual Residence of Decedent		0.5				July 1	0,1942	Mary	Tanu
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Mary	ğ	Maryland Carolin	0	Den	ton						1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number		1 2011	•	10f. Zip Code			10g. Citizen of	What Cour	itry?
	h wit	a D	6652 Laurel Grov	e Road			216	529			USA	
	deat	Funeral	11. Marital Status	12. Was Deceden Armed Forces		S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (	Specify Yes or No-	14. Ra	ce - Americ	
9	or Ite	F.	1 Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		1□Yes 2ŪNo	Specify:		Specia	hv-	
ğ	ural',	d by	3 Widowed 4 Divorced		:			41				ack
က်	"nat	Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual Occupa kind of work done o DO NOT use retired	uring most of wo	orking	16b. Kind of E	susiness/Ind	dustry
2	within than than	du	Elementary/Secondary (0-12)	College (1-4or	r 5+)		oup Leade			Kraf	t Fo	oods
2	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene Hygiene interesten "natural", or items 23a or 28a-f show ant, it e Madical Examiner must be intiffied at any.	ပ္	17. Father's Name (First, Middle, Last)			GI	Jup Leade.		me (First, Middle,			
ä	e d fall be	To Be	Jessie	Stanf	ford			Doz	othy	Acree		
$\mathbf{\Sigma}$	2 should be filed within 72 hours after death with the Marylan, and Mental Hygiene, and Mental Hygiene is an extended other than "naturat", or Items 23a or 28a-1 show Is marked other than "naturat", or Items 23a or 28a-1 show raumatic event, Ite Madical Examiner must be inclined at	F	19a. Informant's Name/Relationship (7			19b. Mailir	ng Address (Street a				, State, Zip	Code)
Š	1 and 2 Health a tam 27 is		Shirley Acree	/ Wife		665	52 Laurel	Grove H	Road, Den	ton,Mar	yland	1 21629
Ψ.	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition		1 ~	lace of Dispo	sition (Name of matory or other place	g)	Date	20c. Location	- City or To	wn, State
Ĕ	Pages nent of int: If it ury or o		1 ABurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		Ros	s Cha	pel Cemet	ery 08-2	27-2005	Prest	ton, Ma	aryland
a a	permit Pag Department Important: any injury c		21. Sign nure of Funeral Service Licen	see		22	Name and Addressennie Smi	s of Facility				
<u> </u>	89789		Thoula	Fried	//	4	26 Dover	Street,	Easton,	Marylan	d 216	01
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	plications that cause one caus	ed the death line.	n. Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
	nysician	5. 1	Immediate Cause (Final disease or condition	. Chi	olas	mu	carces	uma				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a								
	Lammer	L	Sequentially list conditions,	b. Due to (or a		unner of\:					-	
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or a	is a consequ	derice or,						
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or a	ıs a consequ	uence of):						
8760,	ate be executed hysician and the burial-transit	dical E		d								_
687	tificate b ig physical as the b	edic		u								
Вох	eath certific attending p for use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Testania erasaasaa			23d. Da	ate of delive	ery
m.	death e atte id for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	at time of de		]Ectopic pregnancy ] Other (specify)			М	onth	Day Year
P.O.	thet the de ed by the detached	Physician/Me	9 🗆 Unknown	9□ Unknown								
s,	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	by F	Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the u	nderlying cause give	en in Part I.				ne cause of death?
ב	w requir been si should								1 🗆 \	res 2 <b>350</b> o	3   Prot	ably 4 Unknown
င်	has be	Completed							24a. Was autop	sv	prior to co	psy findings available mpletion of cause of
<u>~</u>		Co							1 ☐ Yes	rmed? 2000	death?	2□ No
≡ Ita	Physician: The I this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Manital			Oth		eath (Check only o	ne)		
5	Physi this c	မ	1 Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpaties 28b. Time of		4   Nursing	Home 5 sesion 128d. Describe I			y)
Division of Vital Record	ding After	tion	27. Manner of Death  1 SNatural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of In (Month, E	Day Year)	Injury	Worl	(? Yes 2 □ No	Zog. Dosonbo	iow injury cood	1100	
<u>s</u>	Attending is death. actor: After by the fune.	fica	3 Suicide 6 Could not b	e 28e. Place of I	njury - At ho	ome, farm, st	reet, factory, office				ber or Rura	I Route Number,
2	after after Dirac d in by	Certification:	4 Homicide	building,	etc." (Specify	y)	•		City or Tov	vn, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edicai C	29a. Certifier (Check only one)  Certifying Ph	ysicien: To the bes	of examina	wledge, deat tion and/or in	h occurred at the tin evestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place	anner as s , and due to	tated. the cause(s)
	To the P within 24 To the F complete	Me	29b. Signature and title of certifier	2 000			29c. License	number		29d. Date sign	ed (Month,	Day, Year)
)	->-0		> //// The	We	m			3528	4	8/19	105	
			30. Name and address of person who	completed cause of	f death (Item	23а) (Туре	Print)	( 1	y ste	- 1		12//01
			HWOREH AL	wan	0 2	17 8	Wast	ungro	1 01 6	East	n mi	14601
	Sta Registi		31. Date filed (Month, AUG 2 2	2005	strar's Signa	iure	Six					

1. Decedent's Name Mark  4a. Facility Name (I Southern M 5. Social Security N 578-72-414 Usual Residence of 10a. State Maryland  10e. Street and Nur 1904 Cath 11. Marital Status 1828 Never Marri 3 Widowed	aryland umber 6 Decedent 10b. County Prince	Anthony  n, give street and numb  Hospital  6. Sex 152M 2 F  George's	. Age (In yrs. la	Yrs.	4b. City, Town, of Clinton If Under 1 Year Months Days		2. Date of Do August  8. Date of Bi (Month, D. May 18,	14, 200 4c. 0 Prth ay, Year)	County of Death	
Southern M 5. Social Security N 578-72-414 Usual Residence of 10a. State Maryland 10e. Street and Nur 1904 Cath 11. Marital Status 183Never Marri	aryland umber 6 Decedent 10b. County Prince	Hospital  6. Sex  1 May 2 F	50 10c. City	Yrs.	Clinton If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bi	rth ay, Year)	rince Ge	
5. Social Security N 578-72-414 Usual Residence of 10a. State Maryland 10e. Street and Nur 1904 Cath 11. Marital Status 180Never Marri	umber 6 Decedent 10b. County Prince	6. Sex 2□F 7. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	50 10c. City	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	(Month, D.	rth ay, Year)		orge's
Usual Residence of 10a. State  Maryland  10e. Street and Nur  1904 Cath  11. Marital Status  180Never Marri	Decedent 10b. County Prince	1920M 2□F	50 10c. City	Yrs.	Months Days		(Month, D.	ay, Year)	Q Rieh	- 5C D
Usual Residence of 10a. State Maryland 10e. Street and Nur 1904 Cath 11. Marital Status 180Never Marri	Decedent 10b. County Prince	George's	10c. City	, Town or Loca	ation		May 18.		Cou	place (State or Forei
10a. State Maryland 10e. Street and Nur 1904 Cath 11. Marital Status 180Never Marri	10b. County Prince	George's			ation			1955		Italy
10e. Street and Nur 1904 Cath 11. Marital Status 1828 Never Marri	mber		Acco	leade		· · · · · ·				10d. Inside City Limit
1904 Cath		can Drive		KEEK						1 □ Yes 2√13 N
11. Marital Status 1 XXNever Marri	erine Fr	can Drive	10f. Zip Code					10g. Citize	en of What Cou	untry?
1 XXNever Marri		an brive			20607			USA		
		12. Was Deced Armed Force	ent Ever in U.S	3. 13. W	as Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No	0- 14	4. Race - Amer Black, White	
3 ∐ Widowed		ried 1 ∐ Yes 2			⊒Yes <b>XXX</b> No		7 1 11041 1, 010.7		Specify:Fili	
	- Late I	102/01/02	es:							
(Spec	ify only highe	nt's Education est grade completed)		(Give ki	nt's Usual Occup nd of work done	during most of worl	ding .	16b. Kind	d of Business/I	ndustry
Elementary/Seco	ndary (0-12)		or 5+)			0)		Retai	1 Ice Cr	eam
17. Father's Name	(First, Middle,					18. Mother's Nam	e (First, Middle	, Maiden S	iumame)	
Lucas B	autista					Nativid	ad Enrigo	ıez	ŕ	
19a. Informant's Na	ame/Relations	ship (Type, Print)		19b. Mailing	Address (Street	and Number or Ru	al Route Numb	er, City or	Town, State, Zi	p Code)
John Bauti	eta / Br	rother		11608 H	lickory Dr	ive Ft. Was	hington,	Maryla	nd 2074	44
20a. Method of Disp	position			ace of Disposit	tion (Name of	ce)	Date	20c. Loca	ation - City or T	own, State
			ate   _			′ I	0, 2005	Clin	iton, Mar	yland
21. Signatur of Fu	neral Service	Licensee		22.1	Name a <i>n</i> d Addre	F	EMEN'	EV 10		
Sa	1.140	also h		61	60 Oxon H	ill Read Ox	of Hill,	Maryla	nd 2074.	5 1.A.
23 Art1. Enter th	ne dise se, or nt failure. List	r complications that cau	sed the death.	Do not enter	the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	11-1-1	Approximate Interval Between
Immediate Cause (	Final			4 5 1	1Bn/15N	1				Onset and Death
resulting in death)				7/	1,502.12.	,				
Sequentially list con	nditions	b								
if any, leading to immediate Due to (or as a consequence of):										
that initiated events		c. Due to /or								
,		Due to (or	as a conseque	erice or):						
		d								
IF FEMALE:		23c. If ves. outco	me of pregnan	cv				1		
in the past 12	months?	1 Live birti	h 2 ∐ Fetal d	death 3 □E		/		23	d. Date of deliv Month	ery Day Year
1 Tyes 2 No 9 Unknown  4 Pregnant at time of death 9 Unknown  5 Other (specify)										
Part II. Other signif	icant condition	ons contributing to deal	th but not resul	ting in the und	erlying cause giv	en in Part I.	23e. Did t	obacco use	o contribute to t	he cause of death?
<u> </u>	SPIRA	MON PNI	EUMO	NIA			10	Yes 2□	No 3 ☐ Proi	bably 4 Donknow
(b) D	IABET	TES MEL	LITUS				24a, Was	an	24b. Were auto	nosy findings available
							autoj perfo	psy prmed?	prior to co death?	impletion of cause of
						26 Place of Dogs			1 LJ Yes	2∐ No
examiner?		Hospital:	atient 2∏E	R/Outpatient	3□ DOA Oth	or			Other (Specia	6.0
				28b. Time of	28c. Injur	y at				<i>y</i> /
2 Accident	investi		Day 15a)	IIIJury						
3 ☐ Suicide 4 ☐ Homicide		ined 289. Place of	Injury - At hon	ne, farm, stree	t, factory, office		28f. Location (	Street and I	Number or Rura	al Route Number,
	-/									
29a. Certifier (Check only one)	1 Certifyir 2 Medical	examiner: On the basi	s of examination	ledge, death o	ccurred at the tir stigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) ar date and pi	nd manner as s lace, and due to	tated. the cause(s)
29b. Signature and	title of certifie	r			29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)
1 ~	1	1	1 D		MD	005780	00	81	115/05	
	Elementary/Seco  17. Father's Name  Lucas B  19a. Informant's Na  John Bauti  20a. Method of Disp  1 Burial 2 (  4 Donation  21. Signatur of Fu  23 An1. Enter the flook, or hea Immediate Cause (Disease or condition resulting in death)  Sequentially list conif any, leading to impause. Enter Under Cause (Disease or that initiated events resulting in death)  IF FEMALE:  23b. Was decedent in the past 12 1 Yes 2 9 Unknown  Part II. Other signification of the past 12 1 Yes 2 1 Yes 2 2 Yes 2 Ye	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Lucas Bautista  19a. Informant's Name/Relations  John Bautista / Br  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S  21. Signatur of Funeral Service  23. Sert. Enter the disease, on hook, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underwing Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant condition  ASPIRA  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pendir investing Suicide 6 Could determ  29a. Certifier (Check only) 2 Medical  29b. Signature and title of certifier  30. Name and address of person	19a. Informant's Name/Relationship (Type, Print)  Lucas Bautista  19a. Informant's Name/Relationship (Type, Print)  John Bautista   Brother  20a. Method of Disposition  1  Burial 2	Elementary/Secondary (0-12)   4   College (1-4or 5+)   4     17. Father's Name (First, Middle, Last)   Lucas Bautista     19a. Informant's Name/Relationship (Type, Print)     John Bautista   Brother     20a. Method of Disposition   1	Elementary/Secondary (0-12)   4   College (1-4or 5+)   Self-File. Discription   Self-File. Dis	Elementary/Secondary (0-12)   4   College (1-4or 5+)   Self-Employed	Elementary/Secondary (0-12)   4   College (1-4or 5+)   Self-Timployed	Elementary/Secondary (0-12)   4   College (1-4or 5+)   Self-Employed	Elementary/Secondary (0-12)   4   College (1-4or 5+)   Self-Bimployed   Retail	Elimentary/Secondary (0-12)   4   Callage (1-4or 5+)   Self-Employed   Retail Ice Cord   Self-Employed   Retail Ice Cord   Self-Employed   Retail Ice Cord   Self-Employed   Retail Ice Cord
DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

AUG 1 6 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena 0 0 5

1 - State

28387

	Registrar			Cer	uncate of	Dealli		Reg. No.				
ician dical	1. Decedent's Name (First, Mid MERRIMAN			USH			2. Date of Domestin	13	2005	3. Time of Death 12:00 PM		
niner	4a. Facility Name (If not instituti	-			4b. City, Town,	or Location of Deat	h	4c. Coun	ity of Death			
	FOX CHASE R	EHAB & NUR	SING CE	NTER		r Spring		Mont	gomery	У		
al	5. Social Security Number	6. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs.		If Under 1 Year Months Days		(Month, D	rth ay, Year)	9. Birthp	place (State or Foreigntry)		
r	577-46-9603	1 M 2.631	71	Yrs.			June 1	8 1934	Sout	h Carolina		
	Usual Residence of Decedent  10a. State 10b. Coun	tv	10c. Ci	ty, Town or Loc	ation					I Od. Inside City Limits		
5									'	1 Types 2 □ N		
octo		e George's	Ну	attsvi]								
Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Coun	itry?		
<u>a</u>	4820 Woodlawn				20784			U.S.A.				
nue	11. Marital Status	Armed F		J.S. 13. V	Vas Decedent of Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puerl	specify Yes or N to Rican, etc.)	o- 14. A: Bi	ace - Americ lack, White,			
by Fi	1 Never Married 2 Ma	If Yes G	2 No ive	1	☐ Yes 2 🛣 No	Specify:		Spec	ifv-			
g D			Dates:						BTa			
ete		ent's Education nest grade completed)	)	16a. Deced	ent's Usual Occu kind of work done	ipation eduring most of world ed)	rking	16b. Kind of	Business/Inc	dustry		
du	Elementary/Secondary (0-12	) College (	(1-4or 5+)			90)						
Completed	12th	( cost)		Ca	shier	40 14-15	/per		vate			
Be	17. Father's Name (First, Middle	e, Last)				18. Mother's Nar						
P			<u> </u>			Carri		Colem				
	19a. Informant's Name/Relatio	nship (Type, Print)		19b. Mailin	g Address (Stree	at and Number or Ru	ural Route Numb	er, City or Tow	n, State, Zip	Code)		
	Norman R. Bush	h/Son				rive Fore	stville	, Maryl	and 2	20747		
	20a. Method of Disposition	2 🗆 8		Place of Dispos	sition (Name of atory or other pla	ace)	Date	20c. Location	1 - City or To	wn, State		
	1 Surial 2 □ Cremation 1 Donation 5 □ Other			rmonv	Cemetery	7 8/19	9/2005	Landoy	vor Ma	ryland		
	21. Signature of Funeral Service	ce/Licensee /	00		Name and Addr	4 49 111	J. B. JE					
	1 1 1 1	la la	· V()	7	474 T.ANT	DOVER ROA						
	23a. Part1. Enter the disease	or complications that	caused the dea						KIIMIND	Approximate		
	shock, or heart failure. I Immediate Cause (Final	ist only one cause on	_							Interval Between Onset and Death		
	disease or condition resulting in death)	a	troke									
l r			(or as a consec	quence of):								
, in	Sequentially list conditions,	0	epsis (or as a consec	allence of								
in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	-	nemia	querice ory.								
Examiner	that initiated events resulting in death) Last	C	(or as a consec	mence of).	<u>-</u>							
		340 10	(0) 40 4 0011000	4001100 01).								
dic		d										
an/Medicai	IF FEMALE:	022 16										
an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live		al death 3 🗌	Ectopic pregnanc	су			Date of delive Month	ery Day Year		
	1 ☐ Yes 2 ☐ No	4∐Preg 9☐Unkr	nant at time of o	death 5□	Other (specify)			"		Day Tour		
sici	O Helmour											
Physicia	9 Unknown	itiana a tit ti :	d = = 44= 6=			won in Darf I	23e. Did	topacco use co	ntnbute to th	he cause of death?		
by Physici	Tarrin on organization	itions contributing to d	death but not res	a trib distance of the state of								
by Physici	Tarrin on organization	itions contributing to d	death but not res	sulting in the un	derlying cause g	THE PARTY.	. 1 🗆	Yes 2∰ No	3 🗌 Prob	ably 4 Unknow		
by Physici	Tarrin on organization	itions contributing to d	death but not res	sulting in the un	derlying cause g	iven in Fait i.	24a. Wa	s an 24b	o. Were autor	psy findings availabl		
by Physici	Tarrin on organization	itions contributing to d	death but not res	sulting in the un	derlying cause g	Notifier atti.	24a. Was auto perf	s an 24b opsy ormed?	o. Were autor prior to con death?	psy findings availabl mpletion of cause of		
Completed by Physici	25. Was case referred to medi		death but not res	sulting in the un	derlying cause g		24a. Wa auto perf 1  Yes	s an 24b opsy ormed? 2 <b>K</b> I No	o. Were autop	psy findings availabl mpletion of cause of		
o Be Completed by Physici	25. Was case referred to medi	cal				26. Place of Deathor	24a. Wa: auto perf 1 Yes  ath (Check only	s an 24b ppsy ormed? 2 No	o. Were autop prior to con death? 1 ☐ Yes	psy findings available mpletion of cause of 212 No		
To Be Completed by Physici	25. Was case referred to medi examiner? 1 □ Yes 2 🛣 No	cal Hospital: 1	Inpatient 2	ER/Outpatient	3□ DOA O	26. Place of Deather: 4 <b>X</b> Nursing F	24a. Wa. auto perf 1 Yes ath (Check only Home 5 Res	s an 24b ppsy ormed? 2 No	o. Were autop prior to con death? 1 \( \sum \text{Yes} \)	psy findings availabl mpletion of cause of 212 No		
To Be Completed by Physici	25. Was case referred to medi examiner? 1 □ Yes 2 🛣 No	cal Hospital: 1 ☐ 28a. Date (Mor		] ER/Outpatient	3 DOA C1	26. Place of Deather: 4 <b>X</b> Nursing F	24a. Wa. auto perf 1 Yes ath (Check only Home 5 Res	s an ppsy ormed? 2X No one)	o. Were autop prior to con death? 1 \( \sum \text{Yes} \)	psy findings availabl mpletion of cause of 212 No		
To Be Completed by Physici	25. Was case referred to medi examiner? 1 □ Yes 2 🛣 No	cal Hospital: 1 28a. Date (Morstigation Id not be	Inpatient 2 [ of Injury nth, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA C1	26. Place of Deather: 4  Nursing Fury at ork?  ☐ Yes 2 ☐ No	24a. Wa. auto perf 1 Yes ath (Check only Home 5 Res 28d. Describe	s an 24b ormed? 215 No one) idence 6 🗆 O how injury occi	b. Were autor prior to con death?  1 Yes  Other (Specify urred	psy findings availabl mpletion of cause of 216 No		
To Be Completed by Physici	25. Was case referred to medi examiner? 1 □ Yes 2 🛣 No	cal Hospital: 1 [ 28a. Date (Morstigation ld not be 28e. Place	Inpatient 2 [ of Injury nth, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA C1	26. Place of Deather: 4  Nursing Fury at ork?  ☐ Yes 2 ☐ No	24a. Was autoperfill Yes ath (Check only Home 5 Res 28d. Describe	s an 24b ormed? 215 No one) idence 6 🗆 O how injury occi	b. Were autor prior to con death?  1 Yes  Other (Specify urred	psy findings availabl mpletion of cause of 212 No		
Certification: To Be Completed by Physici	25. Was case referred to mediexaminer?  1	ding tigation ld not be mined 28e. Plac build	Inpatient 2 of Injury onth, Day Year) e of Injury - At h	ER/Outpatient  28b. Time of Injury  ome, farm, stre	28c. Inju WG M 1	26. Place of Deather: 4  Nursing Fury at ork?  Yes 2 □ No	24a. Was autoperful Yes ath (Check only Home 5 Res 28d. Describe 28f. Location City or To	s an ppsy ormed? 2 No one) idence 6 O how injury occi (Street and Numbers, State)	o. Were autor prior to con death? 1 ☐ Yes where (Specify urred	psy findings available impletion of cause of 2 No No No No No No No No No No No No No		
Certification: To Be Completed by Physici	25. Was case referred to mediexaminer?  1	ding ding ding stigation ld not be mined 28e. Plac build 28e.	Inpatient 2 of Injury nth, Day Year)  e of Injury - At hing, etc. (Special of my known basis of examination of the control of	28b. Time of Injury	28c. Inju W M 1 [ Deet, factory, office	26. Place of Deather: 4 X Nursing Fury at ork? Yes 2 No	24a. What autoperful Tyes  ath (Check only)  Home 5 Res  28d. Describe  28f. Location City or To	s an 24b ppsy ormed? 28 No one) idence 6 0 how injury occidence (Street and Number, State)	D. Were autoprior to condeath?  1 Yes  Other (Specify urred)	psy findings available impletion of cause of 2 No No No No No No No No No No No No No		
Certification: To Be Completed by Physici	25. Was case referred to medie examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Penicular	ding ding ding stigation le mined 28e. Plac build 28e. Plac build 28e. Plac and mar	Inpatient 2 of Injury oth, Day Year) e of Injury - At hing, etc. (Speci	28b. Time of Injury	28c, Inju Wo M 1 [  occurred at the lestigation, in my	26. Place of Decither: 4 K Nursing Fury at ork?  Yes 2 No	24a. What autoperful Tyes  ath (Check only)  Home 5 Res  28d. Describe  28f. Location City or To	s an 24b ormed? 2 No one) idence 6 O how injury occi (Street and Number, State)	b. Were autoprior to condeath? 1 Yes  Other (Specify urred)	psy findings available impletion of cause of 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2		
To Be Completed by Physici	25. Was case referred to mediexaminer?  1	ding ding ding stigation le mined 28e. Plac build 28e. Plac build 28e. Plac and mar	Inpatient 2 of Injury nth, Day Year)  e of Injury - At hing, etc. (Special of my known basis of examination of the control of	28b. Time of Injury	28c. Inju We M 1 [ Deet, factory, office occurred at the lestigation, in my	26. Place of Decither:  4 X Nursing Fury at ork?  Yes 2 No  time, date and place opinion, death occurse number	24a. What autoperful Tyes  ath (Check only)  Home 5 Res  28d. Describe  28f. Location City or To	s an 24b ppsy ormed? 28 No one) idence 6 0 how injury occidence (Street and Number, State)	b. Were autoprior to condeath? 1 Yes  Other (Specify urred)	2 No  Al Route Number,  tated.  to the cause(s)		
Certification: To Be Completed by Physici	25. Was case referred to medie examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Penicular	ding ding ding stigation le mined 28e. Plac build 28e. Plac build 28e. Plac and mar	Inpatient 2 of Injury nth, Day Year)  e of Injury - At hing, etc. (Special of my known basis of examination of the control of	28b. Time of Injury	28c, Inju Wo M 1 [  occurred at the lestigation, in my	26. Place of Decither:  4 X Nursing Fury at ork?  Yes 2 No  time, date and place opinion, death occurse number	24a. What autoperful Tyes  ath (Check only)  Home 5 Res  28d. Describe  28f. Location City or To	s an 24b ormed? 2 No one) idence 6 O how injury occi (Street and Number, State)	b. Were autoprior to condeath? 1 Yes  Other (Specify urred)	psy findings available impletion of cause of 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2		

DHMH 17 Rev 1/2001

Staté

Registrar

AUG 1 6 2005

Street and Number  0730 Piney  Iarital Status  XNever Married 2 M  Widowed 4 Divord	f Mary 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	yland Ho  M 2 F 7. A  Road  2. Was Deceden Amed Forces 1	DSPITE Age (In yrs. 34  10c. City 10	y. Town or Lo Call  16a. Deced (Give life.) Aircr  19b. Mailir 19756 Place of Disponementary, crar Georg	If Under Months  If Under Months  Months  Months  If Under Months  If Unde	p Code 20620 p Code 20620 p Code 2081 No coupations do not during the first of the	panic Origin' Mexican, Pi Specify: ion ring most of Ex 8. Mother's Luc id Number of 11 Rd of Facility	RIS. 8. Date of (Month, Sept.)  7. (Specify Yes or uerto Rican, etc.)  working  Name (First, Midely Demen or Rural Route Number of Pare 25–2005  rinsfierd, Long.	Birth Pay, Year, 2, 1  10g. Ci Uni No.  16b. k  the mber, City of the Wall Id Fur	y 2005 County of De  9. B 970  N  izen of What C  ted Sta 14. Race - Am Black, Wh Specify: ind of Busines U.S. Governm Sumame)  or Town, State, MD 20 cocation - City of ey Lee neral	5:35 PM     ath     ath     ath     ath     ath     ath     aryland     10d. Inside City Limits     1 Yes 2 No     No     Country?     ates     arican Indian,     ite, etc.     White     s/Industry     aent     Zip Code     0650
acility Name (If not instituted in iversity of cial Security Number 14-08-7472  I Residence of Decedent State 10b. Cour Security Number 10b. Cour State 10b. Cour Security Number 10c 10c 10c 10c 10c 10c 10c 10c 10c 10c	f Mary 6. Sex 1 1 2 N  The second of the sec	ry s  Road	DSPITE Age (In yrs. 34  10c. City 10	yrs.  yrs.	If Under Months  cation  away  10f. Zij  Was Dece for Yes, special of Yes, special of Yes, special of Yes  Caft  Townstion (Namatory or Caft)  See S. Name at 2955	p Code 20620 p Code 20620 p Code 2081 No coupations do not during the first of the	panic Origin' Mexican, Progression Find Mumber of  11 Rd  18 Active Technology  11 Rd  18 Active Technology  11 Rd	RIS. 8. Date of (Month, Sept.)  7. (Specify Yes or uerto Rican, etc.)  Working  Name (First, Midely Demen or Rural Route Number of Pate 25–2005  Tinsfie add, Long.	Birth Day, Year, 2, 1  10g. Ci Uni No- 16b. k  the mber, City 20c. L Vall Ld Fur	gramme)  9. By 970 M  9. By 970 M  9. By 970 M  9. By 970 M  9. By 970 M  98 By 970 M  98 By 970 M  98 By 970 M  98 By 9	inhplace (State or Foreign Country)  [aryland]  10d. Inside City Limits 1   Yes   X   No  Country?  Ites Inerican Indian, lite, etc.  White  s/Industry  Itent  Zip Code)  1050  Town, State  Maryland  Ome, F.A.  10050   0279  Approximate
Iniversity of cial Security Number 14-08-7472  Residence of Decedent State 10b. Cour 1	f Mary 6. Sex 1 1 2 N  The second of the sec	yland Ho  M 2 F 7. A  Road  2. Was Deceden Amed Forces 1	DSPITE Age (In yrs. 34  10c. City 10	y, Town or Lo Call  16a. Dece (Give life.) Aircr  19b. Mailir 19756 Place of Disponemetery, crec Georg	If Under Months  If Under Months  Months  Months  If Under Months  If Unde	Balt In 1 Year Days  Days  Doys  panic Origin' Mexican, Progression Find Mumber of  11 Rd  18 Active Technology  11 Rd  18 Active Technology  11 Rd	RIS. 8. Date of (Month, Sept.)  7. (Specify Yes or uerto Rican, etc.)  working  Name (First, Midely Demen or Rural Route Number of Pare 25–2005  rinsfierd, Long.	Birth Day, Year, 2, 1  10g. Ci Uni No- 16b. k  the mber, City 1town 20c. L Vall Id Fur	9. By Moderate of What Coted State of What Coted State of What Coted State of What Coted State of What Coted of Busines U.S.  GOVERNM State of Town, State of Town, State of What Coted of Coted	inthplace (State or Foreign Country)  [aryland]  10d. Inside City Limits 1	
cial Security Number  14-08-7472  I Residence of Decedent State 10b. Cour  ID S  Street and Number  0730 Piney  Iarital Status  XNever Married 2 M  Widowed 4 Divorce  (Specify only high  mentary/Secondary (0-12  12  Intermediate B  Intormant's Name/Relation  I Burial 2 Cremation  I Donation 5 Other  Signature of Funeral Service  Kyle Simo  Part 1. Enter the disease, shock, or heart failure. Lediate Cause (Final ase or condition liting in death)  Intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertially list conditions, intertial weeks.	6. Sex 1 1 1 1 N  Point  Point  Idarned  Ident's Educathest grade co  Iden	Road  2. Was Deceden Armed Forces 1 — Yes 2 ½ 1 Yes, Give Year or Dates ation Completed)  College (1-4or ell, Jr. moval from State ell, Jr. moval from State ell, Jr. moval from State ell, Head a Due to (or a	ther)  and checked the death line.  and checked the death line.  and checked the death line.	y, Town or Lo Call  16a. Dece (Give life.) Aircr  19b. Mailir 19756 Place of Disponemetery, crec Georg	Months  cation  AWAY  101. Zij  104. Zij  105. Zij  107. Yes  dent's Usukind of wich  Caft  Town  sition (Na  matory or case)  Name at  2055	p Code  20620  deent of Hisp  corrections of done du  se retired)  Paint  (er Hi  me of  other place)  Episc  nd Address	panic Origin' Mexican, Program of the Care of Number of 11 Rd  18 Mother's 11 Rd  19 Mother's 12 Rd  10 Rd  11 Rd  10 Facility F	(Month, Sept.)  (Specify Yes or userto Rican, etc.)	10g. Ci Uni No- 16b. k  the mber, City 1town 20c. L Vall Id Fur	izen of What Coted Sta  14. Race - Arr Black, Wh Specify: ind of Busines U.S. GOVERNIT Sumame)  or Town, State, MD 20 occation - City of ey Lee neral	In the state of th
Residence of Decedent State 10b. Cour Street and Number 10730 Piney Iarital Status IX Never Married 2 Meneral Meneral Meneral Status IX Never Married 2 Meneral Menera	Point  Point  Iarned  Ident's Educathest grade of the Last)  Iackwell  Inchination of the Company of the Licensee  Inchination of th	Road  2. Was Deceden Amed Forces 1	ther)  to DVR  MO1206  and che death	Jean Decer (Give life).  19b. Mailir 19756 Place of Disposementary, crer Georg	was Decedif Yes, spending Address:  Townstition (Namatory or or oge \$ 2.055	p Code 20620 Ident of Hisporty Cuban, 2 No Ident of Cupation of Coupation anic Origin' Mexican, Pi Specify: ion ring most of Ex 8. Mother's Luc id Number of 11 Rd of Facility	Sept.  R (Specify Yes or uerto Rican, etc.)  Working  Name (First, Midely Demen r Rural Route Number of Date 25-2005  Trinsfie and, Lona:	10g. Ci Uni No- 16b. k  the mber, City 1town 20c. L Vall Id Fur	izen of What Coted Sta  14. Race - Arr Black, Wh Specify: ind of Busines U.S. GOVERNIT Sumame)  or Town, State, MD 20 occation - City of ey Lee neral	10d. Inside City Limits   1	
State 10b. Cour  Street and Number 10730 Piney Iarital Status  Where Married 2 Melorida Melor	Point  Point  Idarried  Ident's Educat  Ident's Ident'	Road  2. Was Deceden Amed Forces Amed Forces I   Yes. Give Year or Dates ation completed)  College (1-4or ell, Sr. e. Print brote ell, Jr. moval from State  per Autions that cause cause on each Head a Due to (or a	ther)  be 20b. Pc St.  DVR MO1206  ed the death line.  and ch	Call  16a. Decedification of the control of the control of Disponentery, crecipitation of the control of the co	Was Dece I Yes, spe I Yes dent's Usu kind of we Do NOT Caft Tow sition (Na natory or Se S Name at 2955	p Code  20620  Ident of Hisp scrip Cuban.  2 No  Ident Gore du iss retired)  Paint  In the Companion of the Companion of the Cuban  See Hisp The Companion of t	Specify:  ion ring most of er  18. Mother's Luc of Number of 11 Rd  18. 8- of Facility I	Name (First, Mid Cy Demen r Rural Route Nut Leonard Date 25-2005 rinsfie	Uni  16b. k  16b. k  16b. k  16b. k  16c. Liv  1count	ted Sta  14. Race - Arr Black, Wh Specify:  ind of Busines  U.S. GOVERNIT Sumame)  or Town, State, MD 20 cocation - City of the City of the Cocation - City of the	Town, State  Maryland  ome, F.A.
Street and Number  20730 Piney  Iarital Status  Never Married 2 M Widowed 4 Divorce  15. Deced (Specify only high mentary/Secondary (0-12 12  Iather's Name (First, Middle Status)  Informant's Name/Relatic Imperial 2 Crematic Method of Disposition Method of Disposi	Point  Itarried lend's Educathest grade control (Itarried lend)  Itarried lend's Educathest grade control (Itarried lend)  Itarried lend's Educathest grade control (Itarried lend)  Itarried lend's Education (Itarried lend's le	Road  2. Was Deceden Amed Forces Amed Forces I   Yes. Give Year or Dates ation completed)  College (1-4or ell, Sr. e. Print brote ell, Jr. moval from State  per Autions that cause cause on each Head a Due to (or a	ther)  ther)  by  MO1206  ed the death line.  and ch	16a. Decedor (Give life)  Aircr  19b. Mailir  19756  Place of Disponentery, crer  Carre	Was Dece if Yes, spe i Gyes, spe i Gyes dent's Usus kind of with DO NOT u Caft  Town sition (Na matory or S R. Name at 2955	p Code  20620  Ident of Hisp scrip Cuban.  2 No  Ident Gore du iss retired)  Paint  In the Companion of the Companion of the Cuban  See Hisp The Companion of t	Specify:  ion ring most of er  18. Mother's Luc of Number of 11 Rd  18. 8- of Facility I	Name (First, Mid Cy Demen r Rural Route Nut Leonard Date 25-2005 rinsfie	Uni  16b. k  16b. k  16b. k  16b. k  16c. Liv  1count	ted Sta  14. Race - Arr Black, Wh Specify:  ind of Busines  U.S. GOVERNIT Sumame)  or Town, State, MD 20 cocation - City of the City of the Cocation - City of the	Town, State  Maryland  ome, F.A.
Informant's Name/Relation  Mylever Married 2 Mylever Married 2 Mylever Married 2 Mylever Married 2 Mylever Married 4 Divorce  (Specify only high properties of the Specify only high properties of Specify only high properties of Specify only high properties of Specify only high properties of Specify only high properties of Specify on the Specific on Specify on the Specific on Specific on Specify on the Specific on Specify on the Specific on Specific on Specify on the Specific on Specify on the Specific on Specific on Specify on the Specific on Specify on the Specific on Specifi	larned sed sed sed sed sed sed sed sed sed s	2. Was Deceden Armed Forces 1 Tyes, 2 G If Yes, Give Year or Dates ation completed)  College (1-4or ell, Sr e, Print brote ell, Jr moval from State  read ations that cause or cause on each Head at Due to (or a	ther)  ther)  by  MO1206  ed the death line.  and ch	16a. Dece (Give life.) Aircr 19b. Mailir 19756 Place of Dispo semetery, crer Georg	Was Dece 11 Yes 12 Yes 12 Yes 12 Yes 13 Yes 14 Yes 14 Yes 15 Yes 15 Yes 16 Yes	20620  Ident of Hispoorly Cuban, 2 No.  In Cocupation done du use retired)  Paint  In Secret and the Secret Hime of bother place)  Episc and Address	Specify:  ion ring most of er  18. Mother's Luc of Number of 11 Rd  18. 8- of Facility I	Name (First, Mid Cy Demen r Rural Route Nut Leonard Date 25-2005 rinsfie	Uni  16b. k  16b. k  16b. k  16b. k  16c. Liv  1count	ted Sta  14. Race - Arr Black, Wh Specify:  ind of Busines  U.S. GOVERNIT Sumame)  or Town, State, MD 20 cocation - City of the City of the Cocation - City of the	tes  Terican Indian, ite, etc.  White  Sylndustry  Tent  Zip Code)  650  Town, State  Maryland  Tome, F.A.  10050-0279  Approximate
Arital Status    Never Married 2   M     Widowed 4   Divorce     15. Decederity only high prentary/Secondary (0-12     12     ather's Name (First, Middle     Ames Dale B     Informant's Name/Relatic     Ames Dale B     Method of Disposition     Burial 2   Crematic     Donation 5   Other     Other     Simo     Part   Enter the disease, shock, or heart failure. Lediate Cause (Final ase or condition     Iting in death)     Intended     larned sed sed sed sed sed sed sed sed sed s	2. Was Deceden Armed Forces 1 Tyes, 2 G If Yes, Give Year or Dates ation completed)  College (1-4or ell, Sr e, Print brote ell, Jr moval from State  read ations that cause or cause on each Head at Due to (or a	ther)  ther)  by  MO1206  ed the death line.  and ch	16a. Dece (Give life.) Aircr 19b. Mailir 19756 Place of Dispo semetery, crer Georg	Was Dece If Yes, spe I  Yes I	dent of Hispority Cuban, 2 No  and Occupation done du use retired)  Paint  s (Street and ter Hime of the piace)  Episc  and Address	Specify:  ion ring most of er  18. Mother's Luc of Number of 11 Rd  18. 8- of Facility I	Name (First, Mid Cy Demen r Rural Route Nut Leonard Date 25-2005 rinsfie	noon leader the state of the st	14. Race Am Black, Wh Specify: ind of Busines U.S. GOVERNIT Sumame) or Town, State, MD 20 occation - City of the City of Town Lee neral I	white structure of the	
Never Married 2 Mel Never Married 2 Mel Midowed 4 Divord (Spacify only high prenatary/Secondary (0-12 12 Mel New Yellow) American Service of Service S	larned beed lent's Educations of the Education of the Edu	Armed Forces  1	ther)  ther)  by  MO1206  ed the death line.  and ch	16a. Dece (Give life.) Aircr 19b. Mailir 19756 Place of Dispo semetery, crer Georg	dent's Usukind of wich of wich of wich of wich of wich of wich of wich of with one of the wind of with one of the wind of the	al Occupation done du se retired) Paint s (Street an er Hime of bother place) Episc nd Address	Specify:  ion ring most of er  18. Mother's Luc of Number of 11 Rd  18. 8- of Facility I	Name (First, Mid Cy Demen r Rural Route Nut Leonard Date 25-2005 rinsfie	16b. k  die, Maider  t  dtown 20c. L  Vall  Id Fur	Black, Wh Specify: ind of Busines U.S. GOVERNIT Sumame) or Town, State, MD 20 ocation - City of the City of the Control of the City of the	white  white  sindustry  ent  Zip Code)  1650  r Town, State  Maryland  ome, F.A.  10650-0279  Approximate
Widowed 4 Divorce  15. Deced (Specify only high mentary/Secondary (0-12 12 ather's Name (First, Middle Specify only high mentary/Secondary (0-12 12 ather's Name (First, Middle Specify only high mentary/Secondary (0-12 ather's Name (First, Middle Specify only high mentary Specify Specify only high mentary Specify Spec	dent's Education of the st grade of the st gra	If yes, Give Year or Dates ation completed)  College (1-4or ell, Sr. e. Print) brotell, Jr. moval from State ell, Head a Due to (or a	ther)  to 200. Po St.  DVR M01206  and the death line.	19b. Mailir 19756 Place of Disposemetery, crem Georg	dent's Usukind of wood NoT's caft  ag Address:  Town Sistion (Namatony or See's See's See's See See's See See See See See See See See See Se	Paint s (Street and or street) s (Street and or street) s (Street and or street) s (Street and or street) s (Street and or street) s (Street and or street) s (Street and or street) s (Street and or street) s (Street and or street)	er  8. Mother's  Luc of Number of  11 Rd  8- of Facility I	Name (First, Mid by Demen r Rural Route Nui , Leonare Date 25-2005 rinsfie rd, Lona	dle, Maider t dltown 20c. L Vall Id Fu	GOVERNM State, MD 20 Docation - City of the control	zip Code) 9650 r Town, State , Maryland lome, F.A. 10650-0279 Approximate
Informant's Name (First, Middle Informant's Name (First, Middle Informant's Name/Relatic Informant's Name/Relatic Informant's Name/Relatic Informant's Name/Relatic Informant's Name/Relatic Informant's Name/Relatic Informant's Name/Relatic Informant's Name/Relatic Informant's Name/Relatic Informant's Name/Relatic Informant's Name/Relatic Informant's Informatic I	dent's Education of the st grade of the st gra	ell, Sr. e. Print brotell, Jr. moval from State  per hations that cause of cause on each Head a	ther)  ther)  St.  DVR  MO1206  ad the death line.  and ch	19b. Mailir 19756 Place of Disportemetery, crem Georg	caft  ag Address  Townsition (Namatory or of Ge's  Name and 2955	Paint  (Street and et al. and et	er  8. Mother's  Luc  11 Rd  15 Rd  16 Facility	Name (First, Mid by Demen r Rural Route Nui , Leonare Date 25-2005 rinsfie rd, Lona	dle, Maider t dltown 20c. L Vall Id Fu	U.S. Governm Sumame)  or Town, State, MD 20 occation - City of the control of the	zip Code) 0650 r Town, State , Maryland ome, F.A. 0650-0279
amentary/Secondary (0-12  ather's Name (First, Midd  ames Dale B  Informant's Name/Relatic  ames Dale B  Method of Disposition  Burial 2 Crematic  Companies Solution  Kyle Simo  Part Enter the disease, shock, or heart failure. Lediate Cause (Final ase or condition thing in death)  mentially list conditions, the ential of the conditions of the conditions of the conditions of the conditions of the conditions, the conditions of the conditions, the conditions of	le, Last)  lackwe  lackwe  lackwe  lackwe  n 3 □Ren (Specify)  ce Licensee  ns	ell, Srand brotell, Jrand moval from State Per Nations that cause of each Head a Due to (or a	ther) St.  DVR M01206 ed the death line. and ch	19b. Mailir 19756 Place of Disponemetery, crer Georg	caft  ag Address  Tow sition (Namatory or or ge's  Name at	Paint  S (Street and terr Hime of other place)  Episc  Ind Address	8. Mother's Luc d Number of 11 Rd 8- of Facility I	Name (First, Mid by Demen r Rural Route Nui , Leonare Date 25-2005 rinsfie rd, Lona	dle, Maider t nber, City 1town 20c. L Vall Id Fur	GOVERNIT Sumame) or Town, State, MD 20 occation - City of ey Lee	Zip Code) 1650 In Town, State Maryland Ome, F.A. 10050-0279 Approximate
ather's Name (First, Midd Iames Dale B Informant's Name/Relation Imperior Indiana Imperior Indiana Imperior Imp	lackwe conship (Type lackwe con 3 □ Ren (Specify) ce Licensee ns	moval from State  per  Autions that cause or each Head auto (or a	ther) St.  DVR M01206 ed the death line. and ch	19b. Mailir 19756 Place of Disponemetery, crer Georg	Townsition (Namatory or of Set Set Name at 2955	s (Street and rer Hi me of pother place) Episc	Luc d Number of 11 Rd 8- of Facility I	Leonare Date  25-2005 rinsfie	dle, Maider t nber, City 1town 20c. L Vall Id Fur	or Town, State, MD 20 pocation - City of ey Lee neral	Zip Code) 0650 or Town, State , Maryland ome, F.A. 0050-0279
Informant's Name/Relation  Informant's Name/Relation  Image: Dale B  Method of Disposition  Image: Community  Image: Dale B  Method of Disposition  Image: Dale B  Method of Dale B  Metho	lackwe conship (Type lackwe con 3 □ Ren (Specify) ce Licensee ns	moval from State  per  Autions that cause or each Head auto (or a	ther) St.  DVR M01206 ed the death line. and ch	19756 Place of Disponentary, crar Georg	Townsition (Na. natory or o	s (Street and ter Hime of pather place) Episc	Luc of Number of 11 Rd . 8- of Facility I	Leonare Date  25-2005 rinsfie	t ltown 20c. L Vall Id Fur	or Town, State, MD 20 ocation - City of ey Lee	, Maryland ome, F.A.
Informant's Name/Relation  Image: Dale B  Method of Disposition  Burial 2 Cremation  Donation 5 Other  Signature of Funeral Service  Kyle Simo  Part1. Enter the disease, shock, or heart failure. Lediate Cause (Final ase or condition liting in death)  mentially list conditions, leading to minural ase or line of the condition liting in death.	anship (Type lackwe n 3 □Ren (Specify) ce Licensee nS , or complica	moval from State  per  Autions that cause or each Head auto (or a	ther) St.  DVR M01206 ed the death line. and ch	19756 Place of Disponentary, crar Georg	Townsition (Na. natory or o	er Hi me of other place) Episc nd Address	11 Rd	Leonard Date 25-2005 rinsfie	town 20c. L Vall Id Fur	MD 20 coation - City of ey Lee neral	, Maryland ome, F.A.
Method of Disposition  Disposition  Disposition  Disposition  Disposition  Communication  Communication  Communication  Communication  Communication  Myle Simo  Part1. Enter the disease, shock, or heart failure. Lediate Cause (Final ase or condition ting in death)  Mentially list conditions, in the communication of the co	lackwe	moval from State  per  ations that cause cause on each  Head a  Due to (or a	St. St. DVR M01206 and the death line.	19756 Place of Disponentary, crar Georg	Townsition (Na. natory or o	er Hi me of other place) Episc nd Address	11 Rd	Leonard Date 25-2005 rinsfie Rd, Lona	Vall Id Fur	MD 20 coation - City of ey Lee neral	, Maryland ome, F.A.
Method of Disposition  Burial 2 Cremation  Donation 5 Other  Signature of Funeral Service  Kyle Simo  Part1. Enter the disease, shock, or heart failure. Lediate Cause (Final ase or condition ting in death)  mentially list conditions, the conditions of the conditions of the conditions of the conditions of the conditions, the conditions of the conditions	on 3 □Ren (Specify) ce Licensee ∏S	per Nations that cause of cause on each Head & Due to (or a	St. St. DVR M01206 and the death line.	Place of Disponentially, cremetery, cremetery, cremetery, cremetery, cremeters, cremeter	sition (Na matory or o ge s . Name at 2955	me of other place) Episc nd Address	. 8-	25-2005 rinsfie kd, Lona	Vall Id Fur	ey Lee neral	, Maryland ome, F.A.
EDonation 5 Other Signature of Funeral Service Simo Part1. Enter the disease, shock, or heart failure. Lediate Cause (Final ase or condition ting in death)  mentially list conditions, the same of th	(Specify) ce Licensee  ns or complica	per Nations that cause of cause on each Head &	DVR MO1206 ed the death line.	22 5 22 h. Do not ent	ge's Name at 2955	Episc	of Facility	rinsfie d, Lona	ld Fu rdtow	neral H	ome, F.A. 0650-0279
Kyle Simo  Part1. Enter the disease, shock, or heart failure. Lediate Cause (Final ase or condition titing in death)  mentially list conditions, it leading to immediate e. Enter Underlying to (Disease or injury initiated events	NS , or complica	ations that cause o cause on each Head a	M01206 ed the death line. and ch	5 22 h. Do not ent	2955		of Facility	rinsfie d, Lona	ld Fu rdtow	neral H	ome, F.A. 0650-0279
Part 1. Enter the disease, shock, or heart failure. Lediate Cause (Final ase or condition liting in death)  tentially list conditions, the conditions of the	or complica	Head a	ed the death line. and ch	h. Do not ent		Holly	wood I		_	n, MD 2	Approximate
shock, or heart failure. Leadiate Cause (Final ase or condition liting in death)  entially list conditions, leading to minudiate e. Enter Underlying e. (Disease or injury nitiated events	or complica ist only one	Head a	and ch		er the mod						Approximate
	d.	Due to (or a	is a consequ	uence of):	njuri	es					Onset and Death
MALE: Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c	c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fetal	Ideath 3	Ectopic p Other (s)					23d. Date of de Month	Blivery Day Year
I. Other significant cond	litions contri	ributing to death	but not resi	ulting in the u	nderlying o	cause given	in Part I.	Tr.		-	to the cause of death?  Probably 4 □Unknown
			-					24a. W	as an	24b. Were a	autopsy findings available completion of cause of
								— au pe N∑ Ye	itopsy erformed? s 2 ☐ No	death?	completion of cause of
Vas case referred to med	ical					2	26. Place of	Death  Check on		A	3 20140
xaminer? XYes 2 □ No	1,000			ER/Outpatien			4 1 INUISI	ig Home 5□R	sidence	6 ∐Other (Sp	ecify)
				Injury		28c. Injury a Work?	at sz.	28d. Descrit	e how inju	ry occurred	
MANORON	ild not be						s 2 No	Motoro	yclis	t lost	control
☐ Homicide dete	ermined	building, e	etc. (Specify	y)	eet, factor	y, office		City or	Town, State	) Grea	tenili, MD
(Check only 2 Medic	ying Physic al Examine	cien: To the bes	st of my kno of examina	wledge, death	n occurred vestigation	at the time n, in my opir	, date and pl nion, death o	lace, and due to t	ne cause(s	and manner a	is stated.
ane)		mainol 3			29	c. License r	number		29d. Da	te signed (Mor	oth, Day, Year)
one)	ifier								[		
one)	ifier Le C	FUL)				OCME				Amoniet	21 2005
Signalton and title of cert	let	mpleted cause of	death (Item	n 23a) (Type,		OCME				August	21, 2005
1	lanner of Death Natural Accident Suicide Homicide  Certifier Check only	Accident   Suicide   Homicide   Certifier   1   Certifying Physical International In	Accident   Suicide   Homicide   Certifier   Check only   Certifier   Check only   Certifier   Check only   Certifier   Check only   Certifier   Check only   Certifier   Check only   Certifier   Check only   Certifier   C	Accident   Suicide   Homicide   Suicide   Homicide   Certiffier (Check only one)   Certiffier   Certiffier (Check only one)   Certiffier   Certiffier (Check only one)   Certiffier   Certiffier (Check only one)   Certiffier   Certiffier (Check only one)   Certiffier   Certiffier (Check only one)   Certiffier   Certiffier (Check only one)   Certiffier (Check only	Certifier (Check only)   Check only   Chec	Certifier (Check only one)   Check only one)   Certifier (Check only one)   Certifier one	Certifier (Check only one)   Check only one)   Certifier (Check only one)   Certifier one	Certifier (Check only one)   Continue of Death   Continue of Dea	Certifier (Check only one)   Certifier (Check only one)   Certifier one)	Certifier (Check only one)   Check only one)   Certifier (Check only one	Certifier (Check only one)   Certifier (Che

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elizaboth Parkul Jones August 2040 18,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL Medical NICOMICO REMINSULA 5441364M If Under 1 Year If Under 4 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 🔀 F Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show or other treumatic event, the Madical Examiner must be notified at Some 1 Yes 2 No Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 'naturel', or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or item any injury or other treumatic event, Item Madical Execution 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2X No 1 🗆 Yes Specify þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seafood 17. Father's Name (First, Middle, Lost, 18. Mother's Name (First, Middle, Maiden Sumame, Be City or Town, State, Zip Code) 282 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type 23310 H MilbourneRd / grandaughte 23310 H 200. Place of Disposition (Name of cometery, crematory or other place, DEALISLAND MD 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Deal Island 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician tai one disease or condition resulting in death) one year /Medical Due to (or as a consequence of): Examiner Asovi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by the attending physician tached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 TYes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 ₽No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 JH6 10 1 Inpatient 3□ DOA 1 Tyes 2 ER/Outpatient nerei Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number we who DO 57359 August 1915 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S- DIVISION ST SAUSBURY DK-45HA 1415 NATESAN 31. Date filed (Month, Day, Year) 32. Registar's Signature State AUG 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death 28390 1 - For State Registrar 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month <sup>Year</sup> 2005 **Physician** 1326 Augus t Mabel Irene Bandoian /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel MEdical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Feb. 2, 1926 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min Days 1 □ M 2 1 F 79 218-28-3275 Tennessee Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County item 27 is marked other then "neturel", or Items 23s or 28s-f show other treumatic event, It is Modical Extended and 1 ☐ Yes 2 No Director Annapolis Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 United States Funeral 2574 South Haven Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "neturel", or Item eny injury or other freumatic. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) secretary labor union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. Ramsey Sally Winningham 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Ryce/ son 4400 Ridge Rd. Kitty Hawk, NC 27949 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8-25-2005 Arlington Nat. Cem. Arlington, VA \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition Sepsis Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Methicallin Resistant Stuph Ansens Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine transit neamonia and that initiated events The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): burial-t Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ö Month in the past 12 months 5 Other (specify) 1 ☐ Yes 2 ☐ No the be detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Unknown 1 ☐ Yes peen 24a. Was an autopsy perform Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24b. has page 2 1 ☐ Yes 2 No Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 Inpatient nours after death.

nerel Director: After this
filled in by the funeral d 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury Certification: To the Hospital or Attending (Month, Day Year) Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D00058297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Armod Medical Carle Annapolis MD 21401 MD HowARD OUNG Registrar's Signar 31. Date filed (A Z 2005 State Registrar

			1- State of Maryland		artment of Health and rtificate of Death		2005 2	8391
			Decedent's Name (First, Middle, Last)			2. Date of Death	3.	Time of Death
	Physici /Medic		Ida Louise Bladen			August 1	.3, 2005 1	:30 A M
			4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. County of Death	
			29815 Washington Road		Mechanicsvi		St. Mary'	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 A F 88	(st birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		(ear) Country)	(State or Foreign gton DC
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City,	Town or Lo	cation		10d. Ir	nside City Limits
	f sho	៦	Maryland St. Mary's	Moo	hanicavilla			□Yes X□No
	28a-	rect	10e. Street and Number	Mec	hanicsville 10f. Zip Code	100	J. Citizen of What Country?	
	3a or	<u></u>	29815 Washington Road		20659		US	
	death ms 2	nerg	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?	i. 13. \	Was Decedent of Hispanic Origin? ( f Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American In	idian,
920	urs after el', or Ite	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:	to nican, etc.)	Specify: White, etc.	te
Š Q	72 ho	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation	ndking 16	b. Kind of Business/Industry	у
2	ithin	nple.	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most of wo DO NOT use retired)	1		
2	led w lygier her th		8	W	aitress		Restaurant	
and	Q to D e						iden Sumame)	
ž	hould d Mei mark matic	၉		19b Mailin			City or Town State Zin Code	
M	0,	11						
စ်	Heal Heal tem	1 3	20a. Method of Disposition 20b. Pla	ace of Dispos	sition (Name of		c. Location - City or Town, S	
0 L			1 Aburial 2   Cremation 3   Hemoval from State	-		6-05 Br	entwood, MD	
Ħ	ortar injur							
ä	or Attending Physicien: The law requires that the death certificate be executed that death and Menial Hygiene.  In popartment of Health and Menial Hygiene.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.		) John Hege	H	untt Funeral Hom		f, MD 20604-0	0156
			23a. Part1. Enter the disease, or complications that caused the death.	Do not ento	er the mode of dying, such as cardia	c or respiratory arres	t, App	roximate rval Between
	Physician		Immediate Cause (Final	(	ANCER			et and Death
			resulting in death)		1110001			
Н	Examiner		Sequentially list conditions. b.					
	ed sit	line	cause. Enter Underlying	ance of):				
_	xecut and I-tran	хап		ence of):				
9	be e sician buria	a E		,-				
687	유	) pa	d					
X	nding use a	u/M					23d. Date of delivery	
	death e atte	icla	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of dea				Month Day	Year
Ö	by the	hys	9 ☐ Unknown 9 ☐ Unknown					
	gned be de			_	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the car	
ord	equir en si ould I					1 🗆 Yes	2 No 3 Probably	4 Unknown
ecc	DIVISION OF VITAL RECORDS, P.O. BOX 68/60,  To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 72 within 24 hours after death.  To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 72 within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and injury or other treumatic event, tre Much and injury or other treumatic event, treumatic event, treumatic event, treumatic event, treumatic event, tr	HYPOTHYROLD	ISA	1	24a. Was an autopsy	24b. Were autopsy fi	ndings available ion of cause of	
<u>=</u>		Con				performe	d? death?	
/ita		a	25. Was case referred to medical examiner?					
The Shark's Name (First, Middle, Last)   18 Mother's Name (First, Middle, Last)   18 Mother's Name (First, Middle, Last)   18 Mother's Name (First, Middle, Matter Hellen Boswell   19 Mailing Address (Street and Number of Paula Number, City								
	injury occurred							
2	deat ctor: / the	Ical	3 Suicide 6 Could not be as Black of Injury At hos	ne farm str		28f. Location (Street	et and Number or Rural Rou	ite Number.
<u>S</u> .	i di di	erti	4 Homicide building, etc. (Specify)	,	out actory, only	City or Town,	State)	,
	Hospita 24 hours Funerel tely filled		(Check only 2 Medical Examiner: On the basis of examination	ledge, death on and/or inv	n occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the causurred at the time, date	se(s) and manner as stated.	cause(s)
	thin 2 the	Mec			29c. License number	29d	. Date signed (Month, Day,	Year)
ŧ	F ≱ F 8		V Annangarde					
C			30. Name and address of person who completed cause of death floor	23a) (Turno				
1	84		VIDYASAGAR ANMANO	ZANI	ZA - WITE	DIAIN	I MD THE	169C
	Sta	ite	31. Date filed (Month, Day, Year) 32. Redistrar's Signatu	ILO	Sant a	101111	- , . , ,	· - 12
			AUG 1 6 2005	D 19	Total Contract of the Contract			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 3:00 PM 2005 11, Cornelia Cole August 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Prince Georges Futurecare Pineview Nursing Home Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) Dec • 22, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☐ M 2 □XF Ťenn. 1922 578-20-1193 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ¥Yes 2 ☐ No Clinton P.G. Md. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20735 United States 9106 Pineview Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 21 No Specify: 3 ☑ Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Crawford Hattie Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12100 Dunleigh Court. 19a. Informant's Name/Relationship (Type, Print) Dunleigh Court k, Maryland 20 Constance M. Johnson/daughter Dūnkirk, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/20/05 Washington, DC \* 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final a Dementia resulting in death) Due to (or as a consequence of): Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hypertension Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 XNo 2 🔀 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 3 DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 XNatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of ceptitie D - 24535August 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 7700 Old Branch Ave., Suite C-101, Clinton, MD. Dr. Laxmi Berwa,

To the Hospita within 24 hours To the Funerel

State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Extending round be notified at

or other treumatic event,

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other trea once.

**Physician** 

/Medical

**Examiner** 

burial-transit

use as the

attending physician

requires that the death certificate be exec

Division of Vital Records, P.O. Box 68760,

Funeral Director

Completed by

Be

Examiner

Physician/Medical

þ

Completed

Be

Certification:

Medical

death with the Maryland

Baltimore, Maryland 21215-0036

AUG 1 8 2005

31. Date filed (Month, Day, Year)



			For State Registrar		State	of Mar	yland / De	epartmer Certificat	t of He	ealth ai <i>eath</i>	nd Me		iene	200	5	28393
	DI		1. Decedent's Name (First,	Middle, La	ist)							2. Date of Deal			'ear	3. Time of Death
	Physici: /Medic		Shin ley	F	. 0	olert	an					8	3		25	23:13 M
	Examin		4a. Facility Name (If not in				T A T		Town, or L					County of		
			WASHINGTON  5. Social Security Number		ENTIST Sex		In yrs. last birtho		TAKOM.	If Under 2		9 Date of Birth				Dog (State of Familia
	Funeral Director		579-84-5374	1	1 ☐ M 2 🛣 F	4	_ Vr	Months		Hours	Min.	8. Date of Birth (Month, Day January	Year) 4 ]	959	Sout	ace (State or Foreign ry) <b>h Carolina</b>
and	A L		Usual Residence of Deceder 10a. State 10b. C			1	0c. City, Town o	or Location			-				10	d. Inside City Limits
Maryi	-f sho	jo	MD Mo	ntgo	mery		Silver	Spring								1 Yes 2 □ No
h the	r 28e	irec	10e. Street and Number					10f. Zi	Code			1	0g. Citiz	zen of Wh	at Count	ry?
th wit	23a o ust be	a D	8112 New Ha	mpsh	ire Ave	nue #	204		2090	3			U.	S.A.		
d 2 1 2 1 3 - 0000 filed within 72 hours after death with the Maryland	f Health and Mental Hygiene. sitem 27 is marked other than "naturel", or Items 23a or 28e-f show other traumatic event, the Modical Examiner must be notified at	y Funeral Director	11. Marital Status  1 Never Married 2		12. Was De Armed F 1 ☐ Yes If Yes, G	orces? 2 XNo	er in U.S.	13. Was Dece If Yes, spe 1 ☐ Yes	cify Cuban,	panic Origi Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White, e	tc.
y shou	turel	ed by	3 ☐ Widowed 4 ☐ Div	orced cedent's E	Year or	Dates:	162.0	ecedent's Usu	al Occupati	ion		1		nd of Busi		ack
thin 72	e. an "na Madic	Completed	(Specify only Elementary/Secondary (0	highest gr	ade completed	() (1-4or 5+)	(G	Give kind of wo ife. DO NOT u	rk done dui se retired)	ring most o	of workin	ng .				istry
9d wi	ygien her th nt, the	S	12th				Day	y Care						ivate		
9	and Mental Hygiene. Is marked other than aumatic event, It e M	Be	17. Father's Name (First, M Roosevelt	iddie, Lasi Lee	Jr.				1	Viol		(First, Middle, i : <b>ipp</b>	Maiden	Sumame)		
should	nd Me mark imatic	ပ္	19a. Informant's Name/Rel				19b. N	Mailing Addres	(Street an				City or	Town, St.	ate, Zip (	Code) 20903
2 2	Health au tem 27 Is other trau		Latisha Brew	ster	/Daught	er	811	2 New	Hampsl	hire	Ave.	# 204	Sil	ver S	Sprin	ng,Maryland
s 1 a	of Hei		20a. Method of Disposition	-tion 2 [		- Ctat-	20b. Place of D	isposition (Na crematory or	me of other place)		Da	ate	20c. Lo	cation - Ci	ity or Tow	m, State
Page	ant: If		1 XBurial 2 ☐ Crem.  1 4 ☐ Donation 5 ☐ Oti			n State	George	Washir	gton	8,	/16/	05	Ade1	Lphi,	Mary	land
permit	Department of Healt Important: If item 2 eny injury or other once.		21. Signature of Funeral Se	ervice Lice	hal			22. Name a <b>7474</b>		90		B. Jeni Landov				
	350		23a. Part1. Enter the si ea shock, or heart fallure	se, or con	nplications that one cause on	caused the	e death. Do no									Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition		. Re	abio	whork	Arre	6							Shouls
	Medical xaminer		resulting in death)		Due to	as a c	consequence (f)								· .	n 2
		<u></u>	Sequentially list conditions		b. Dua to	Neu	munica consecuence of								- 6	days
rted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	~	H	hi	hille		206	cres		,				days
icate be executed	physician and the burial-transit	Еха	resulting in death) Last	- 1	C. Due to	o (or as a	consequence of)			LLL	L. 7	_				VICITIFICA
te be	nysicia he bu	edicai		- (	d											
ertifica	ling ph e as t		IF FEMALE:							-						
atho	attending p I for use as	Physician/M	23b. Was decedent pregnation the past 12 months			birth 2	pregnancy □Fetal death ne of death	3 ☐ Ectopic p					2	3d. Date of Month		y Day Year
the de	y the	ysic	1 □ Yes 2 □ No 9 □ Unknown		9□ Unk		ne or dearr	3 🗆 Other (s)	ocity)							
s that	igned by the a be detached i	by Pt	Part II. Other significant co	onditions	contributing to	death but	not resulting in th	he underlying	ause given	in Part I.		23e. Did tol	oacco u	se contrib	ute to the	cause of death?
quire	been sig should b											1 □ Ye	s 2[	□No 3	☐ Proba	bly 4 🛣 Unknown
a v se	as bee 2 sho	Completed									_	24a. Was a		24b. We	re autop	sy findings available
The	n. After this certificate has b funeral director, page 2 s	E C										perform	ned?	dea	ath? Yes 2	pletion of cause of No
cien:	ertific actor,	Be (	25. Was case referred to mexaminer?	edical	Manakati						of Death	(Check only on	е)			
Physi	this cal din	2	1 ☐ Yes 2 🛣 No 27. Manner of Death			Inpatient				4 🗀 INUIS		ne 5 ☐ Reside 8d. Describe ho				
d lig	h. After funer	tlon	1 🛣 Vatural 5 🗆 🗜	Pending nvestigation		e of Injury onth, Day Y	/ear) Zob. 1111	iry M	28c. Injury a Work? 1 □ Ye	at os 2.∐No		ad. Describe no	w injury	Occurred		
Atten	er death rector: by the	ertification;	3 ☐ Suicide 6 ☐ 9	Could not b	28e. Plac	e of Injury	At home, farm					8f. Location (St			or Rural	Route Number,
tal or	el Dire	Cert	4  Homicide		buil	ding, etc.	(Specity)				W	City or Towr	i, State)			
e Hospi	within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 ♣ Ce (Check only one) 1 ♣ Ce	rtifying P dical Exa	miner: On the	basis of e	my knowledge, o xamination and/o d.	or investigation	, in my opin	nion, death	occurre	d at the time, d	ate and	place, and	d due to t	the cause(s)
To the	within To the	Me	29b. Signature and title of o	ertifier				29	c. License r	number		2	9d. Date	e signed (i	Month, D	ay, Year)
			light	olli	e Hu	me	73C_		200	604	43		Ş	191	200	5
21	2		30. Name and address of p	erson who	leted ca	use of dea	th (Item 23a) (Ty	ype, Print)					2		100	20912
_			DR-NATHAL 31. Date filed (Month, Day,	1E Year	J. W	ARCI Bacistrat	55E	7600	CATT	911	AJE	TAK	2001	LA	rk,	mD.
	Sta Registr		AUG 1		05	Ever	JE JA	porte								309, Year) 5 20912- mD

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
Ctate of Maniford / Department of U.	solth and Mantal Hydiana

	1	State of Maryland / Department of Health and No. 1 State Registrar Certificate of Death	vientai myg R	2005 2839			
Physician		. Decedent's Name (First, Middle, Last)  ADDIE M. CATHELL	2. Date of Dear Month				
/Medical Examiner	4	a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4chin Sula legional Medical Center Salisbury	1	4c. County of Death Wicomico			
Funeral Director		214-30-9326  Susual Residence of Decedent  1 M 2 X F 99 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day) JULY 22	, 1906 MARYLAND			
Maryians of show fied at		Oa. State 10b. County 10c. City, Town or Location  IARYLAND WORCESTER SNOW HILL		10d. Inside City Limi 1X Yes 2 □ N			
with the Mar la or 28e-f s Le notified I Director		Oe. Street and Number 10f. Zip Code 310 PURNELL STREET, APT. 21 21863	1	Og. Citizen of What Country?			
1/2 hours after death with the Maryland natural", or tems 23a or 28a-f show lical Examiner must be notified at steel by Funeral Director	y micia	1. Marital Status  1. Marital Status  1. Never Married 2 Married  3. Widowed 4 Moivorced  1. Was Decedent Ever in U.S. Armed Forces?  1. Never Married 2 Married  3. Widowed 4 Moivorced  1. Yes 2 No If Yes, Give 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE			
- 1 30	- Indicated	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/Industry			
should be filed within the Mantal Hygiene. s marked other then umatic avent, the Mantal To Be Comp	D .	7. Father's Name (First, Middle, Last)  HOMEMAKER  18. Mother's Name	ne (First, Middle,	OWN HOME  Maiden Sumame)			
and Ment s marked sumatic s		GEORGE W. CATHELL ELIZATION TO STREET THE STREET TO STREET THE STREET TO STREET THE STRE	ZABETH Iral Route Number	POWELL r, City or Town, State, Zip Code)			
ges 1 and 2 t of Health a if item 27 li or other tra	-	GARY L. BRITTINGHAM/GRANDSON P.O. BOX 176, NEWARK, Method of Disposition  1. Burial 2 Cremation 3 Removal from State  1. Donation 5 Other (Specify)  SUNSET MEMORIAL PARK 8/		ND 21841 20c. Location - City or Town, State BERLIN, MARYLAND			
permit. Fag Department Important: any injury o once.		21. Signatury of Funy al Service Licens 22. Name and Address of Facility	HOME, SEI	LBYVILLE, DE. 19975			
physician and physician and sthe burial-transit sthe burial-transit steepers.	by Physician/Medical Examiner	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, f any, leading to immediate bases. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. ASCUD  Due to (or as a consequence of):  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.		Onset and Death		
ned by the attending physician/Medi			edical	edical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9		23d. Date of delivery Month Day Year
signed by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of o				
The taw requires man the beam beam can age to should be detached for use as page 2 should be detached for use as Completed by Physician/Me	andulo		24a. Was a autop: perfor 1 \( \text{ Yes} \)	sy prior to completion of cause death?			
aing Prnysician. h. Atter this certitic funeral director. tlon: To Be	To Be	lo Be	o Re	0 26	examiner?		ne) ence 6 Other (Specify) ow injury occurred
To the Transplant of Available of the Multiple of Available of the Funanal Director: Attent completely filled in by the funer of the Available	Certifica	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)			
within 24 hours a To the Funaral I completely filled		29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation and occurred at the time, date and place 2 medical Examiner: On the basis of examination and occurred at the time, date and place 2 medical Examiner: On the basis of examination and occurred at the time, date and place 2 medical Examiner: On the basis of examination and occurred at the time, date 2 medical Examiner: On the basis of examination and occurred at the time, date 2 medical Examiner: On the basis of examination and occurred at the time, date 2 medical Examiner: On the basis of examination and occurred at the time, date 2 medical Examiner: On the basis of examination and occurred at the time, date 2 medical Examiner: On the basis of examination and occurred at the time, date 2					
프는도 당   #	Medical	Medica	Medica	29b. Signature and title of certifier 29c. License number	1	29d. Date signed (Month, Day, Year)	
With with with with with with with with w		D 57952  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Babulal San, MD, 106 Hill first ST. # 504B, Sal		8/12/2005			

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 28395 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) August 13, 2005 ear **Physician** 2:40 P M Rose Marie Costanzo /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5900 Shepherd Lane Prince George's Seabrook If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F Months Yrs. 58 Washington, DC Director 578-60-6150 October 5,1946 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show or than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 □ No Director Maryland | Prince George's Seabrook 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5900 Shepherd Lane 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Specify: ð 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Book Binder Printing Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any intry or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Moreland Ching Edward Margaret Charles 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Shepherd Lane, Seabrook, Maryland 20706 Peter Costanzo, Sr./ Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Charles Memorial 8/17/2005 Leonardtown, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Brinstield Echols Funeral Home DP 20622 Elst m00945 Naud Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 II Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation M 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8-15-00 00050 951 mp lung 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Ave Reverdado REVA. S 6510 Kenelworth 20737 . GILL 32. Re strar's Signature 31. Date filed (Month, Day, Year) State AUG 1 6 2005 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiens O.O.F.

			for State of Maryland / Department of He State of Maryland / Department of He Registrar Certificate of D	eath Death		eg. No.	28396
H	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic	al	Glenn Eugene Diamond, Sr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or L	Location of Dooth	8	15 2005 4c. County of Dea	
	Examin	er	Atlantic General Hospital  Atlantic General Hospital  Ber			Worces	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		8. Date of Birth (Month, Day 8 / 10 / 19		rthplace (State or Foreign ountry)
	Director		178-24-1640 73 Yrs.	TIOGIO INIII.	8/10/19	32 P	A ''
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary 1-f sh	tor	MD Worcester Berlin				1 X Yes 2 ☐ No
	th the	Director	10e. Street and Number 10f. Zip Code		1	0g. Citizen of What C	ountry?
	ath wi	rail	10 Franklin Square 21811			USA	
_	items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ▼ Married  1 □ Never Married 2 ▼ Married  1 □ Never Married 2 ■ Never Married	panic Origin? (Spec i, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
9500-61212	hours after death with the Maryland turel', or items 23a or 28a-f show al Freching the notified at	by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1947	Specify:		Specify: W	hite
2 C	72 hours "naturel",	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du lifle. DO NOT use retired)	tion uring most of workir	ng	16b. Kind of Business	s/Industry
7	withir ne. then	mpl	Elementary/Secondary (0-12) College (1-4or 5+)			Sami Tru	uole
-	Hyg Hyg Sthe ent,	e Co	11 den bilve	18. Mother's Name	(First, Middle,	Semi Tri Maiden Sumame)	иск
yiand	0 = 0 >	To B	Tobias Diamond	Emma :	Stouffe	r	
Mary	and Men ie marke	Г	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and	nd Number or Rural	Route Number	r, City or Town, State,	Zip Code)
	and 2 ealth m 27		Mary Brenda Diamond 10 Franklin Squ				
Baitimore,	t. Pages 1 and 2 should b rtment of Health and Ments rtant: if Item 27 is marked njury or other traumatic s		20a. Method of Disposition 1 ☐ Burial 2 【★Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetary, crematory or other place)	1		20c. Location - City of	
	nit. Parantmen ortant: injury		'4 □Donation       5 □Other (Specify)       Cape Henlopen Cres         21. Signature of Fue ral Service Licensee       22. Name and Address	m. 8/1/ s of Facility The	/2005 Rurba	Frankford	d, De
n	Depril		Mary Bucker 108 William				
ı			23a Part1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	, such as cardiac or	respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	desse			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
ı		er	Sequentially fist non-ditions if any, leading to immediate Due to (or as a consequence of):				
	cuted od ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events  c.				
Š,	oe exe cian ar rurial-t		resulting in death) Last Due to (or as a consequence of):				
09/89	rificate be executed og physician and as the burial-transit	edlcal	d				
ROX	nding use as		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	elivery
	that the death cer led by the attendir detached for use	Physician/N	in the past 12 months?  1  Yes 2 No  A Pregnant at time of death  5 Other (specify)			Month	Day Year
J.	law requires that the as been signed by th 2 should be detache	Phys	9 Li Unknown	a ia Dawl	220 Did to	bacco use contribute t	a the sauce of death?
ďS,	signer d be d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	THI FAILS.			robably 4 Junknown
Hecord	w require been sig should b	ompleted			24a. Was a	ın 24b. Were a	utopsy findings available
	eicien: The law certificate has l irector, page 2 s	omp			autops perfor 1 Yes	sy prior to med?/ death?	completion of cause of
VITal	stifica ctor, p	Be C	evaminer?	26. Place of Death			
0	Physicien: r this certific ral director,	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther.	4 - Italiania Hon		ence 6 Other (Spe	ecify)
	ding h. After fune	tion:	27. Mannerf of Death  1 ☑Natural 5 ☐ Pending (Month, Day Year)  2 ☐ Accident investigation  28a. Date of Injury 28b. Time of Injury 4 Injury 4 Nork?  M 1 ☐ Ye	at ? ′es 2 □ No	80. Describe n	ow injury occurred	
DIVISION	r Attending er death. rector: After by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		8f. Location (S. City or Tow	treet and Number or F	lural Route Number,
ā	7 3 7 6		4 Homicide building, etc. (Specify)				
	To the Hospital of within 24 hours af To the Funerel D completely filled in	ledical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time (Check only one)  Medicel Examiner: On the basis of examination and/or investigation, in my opin and manner stated.				
	To the within 2 To the complet	×	29b. Signature and title of certifier 29c. License of	number	2	9d. Date signed (Mon	th, Day, Year)
			1442 U.O. H442	283		8/15/2	005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7 71011			
	Sta	te	Robert Durkin 9733 Healthway Dr., Berlin, MD  31. Date filed (Month, Day, Year)  AUG 17 2005  32. 5 gistrar's Signature  Specific Specific	2 21011			
	Registi		AUG 1 ( 2005 ) Species				

State of Maryland / Department of Health and Mental Hygiene 200528397 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 14:00 PM DARBY MARION 08 11 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL MEDICAL Miconic . 50/136414 If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 1 MM 2□ F 215-14-3258 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shoy traumatic event, the Mudical Evar-mer must be notified at Wicomico 1 des 2 No Be Completed by Funeral Director SALISBURY 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with ö 31840 USA 700 LINCOLN AVE or Itema 23a 12. Was Decedent Ever in U.S. Anned Forces?

1. DYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: WHITE 3 Widowed 4 □ Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SMES INSURANCE 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If Item 27 is marked oth CATHERINE (UNKNOWN) GEORGE DAABL 19a. Informant's Name/Relationship (T. e, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 E, LINCOLM AVE STUBBURY, MD A1804 BARBARA MITCHELL other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department of Important: If any injury or once. SALKBURY, MD 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Name and Address of Facility

23. Name and Address of Facility

23. Name and Address of Facility

23. Name and Address of Facility

23. Name and Address of Facility

23. Name and Address of Facility

23. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address of Facility

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

21. Name and Address of Facility

21. Name and Address of Facility

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

26. Name and Address of Facility

27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address o Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Artun 01/29/2 **Physician** Ceronary /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of by Physician/Medical Examiner Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Honknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 2 4No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 40 ဥ 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Zi\_J Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8/11/05 D 54807 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St. Salisbury MD 21801 AGARWAL , M. D. gistrar's Signature GT 5 2005 boarde State Medita. Registrar

Physician Middled   Sammer   M	1- º	For State Registrar		State of Ma	aryland /	Depart	tment of	Health an	d Mental H	lygiene Reg. No	2005	28398
Doctor's Community Hospital   Lanham   Prince George	ysician Medical		Griffin	n Arthu	r Edw				Hugus	st 13	2009	
10a. State   10b. County   10c. City, Town or Location   10d. Inside County   10d. Inside C	5. Soo eral 23.	Poctor ' ocial Security Nur 39-12-0	s Commu	nity Hos	e (In yrs. last b	nirthday)	Lai	nham	Hrs. 8. Date of E	Birth Day, Year)	rince 9. Birti	Georges hplace (State or Foreign untry)
Second to the second to the		State	10b. County									10d. Inside City Limits 1 ✓ Yes 2 ☐ No
Tyes   Specify   Black   Specify   Speci	10e. S		ber	Prooks			10f. Zip Code					••
Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	1 by Funeral	Marital Status I 🗌 Never Married	d 2 Married	12. Was Decedent I Armed Forces? 1 Yes 2971	Ever in U.S.	13. Wa	s Decedent of es, specify Cul	Hispanic Origin ban, Mexican, P	? (Specify Yes or I uerto Rican, etc.)	No-	14. Race - Ame Black, White	e, etc.
Physician / Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death)  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death)  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and Due to (or as a consequence of):  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and Due to (or as a consequence of):  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and Due to (or as a consequence of):  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and Due to (or as a consequence of):	Completed	(Specify lementary/Second	y onfy highest grad dary (0-12)	de completed) College (1-4or 5	+)	(Give kin life. DO	d of work done NOT use retire	during most of		I	Private	,
Physician / Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death)  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death)  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and Due to (or as a consequence of):  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and Due to (or as a consequence of):  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and Due to (or as a consequence of):  25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and Due to (or as a consequence of):	To Be	Wi	ll Edwa					Mel	via Als	ston	,	
Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Cyr	nthia 1	Edwards		r  33	503 F	KIDDII	ng Bro	oks Ct.	Md.	20721	
Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	20a. N	1 Burial 2 4 Donation 5	remation 3 F	)	ce <i>m</i> ete	rdale	e Park	8/	16/05	Riv	verdale	e, Md.
Physician /Medical Examiner  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	23a.	. Part1. Enter the	disease, or comple	Hacfut	the death. Do	Ha 81	ackett   4- Up   he mode of dy	shur S	neral Ch Street, diac or respiratory	nape] N.W.	l, Inc.	Approximate
Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):	ical Imme	nediate Cause (Finance or condition		a. Pn	eun		nia					Interval Between Onset and Death
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	carie trans	initiated events	st	Due to (or as a		, 						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of contribute to t	nysician/Med	Was decedent p in the past 12 mg 1 Yes 2 N	ionths?	1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal death			у		2		
24a. Was an autopsy findings prior to completion of clearly performed? performed?	Part II.	II. Other significa	ant conditions cor	ntributing to death bu	t not resulting i	in the under	rlying cause gr	ven in Part I.			/	the cause of death?
6 10	comp								- aut	opsy formed?	prior to co	ompletion of cause of
25. Was case referred to medical examiner? 1   Yes   2	<u> </u>	examiner?		1 Minpatier			3□ DOA Ott	ner			3 □Other (Speci	fy)
27. Manger of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	ortifical	Natural Accident Signatural	investigation 6 Could not be	(Month, Day 28e. Place of Inju	ry - At home, fa	Injury	M 1	rk?	28f. Location	(Street and	d Number or Rur	al Route Number,
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	edical C	( orroan bring	Certifying Phys	TIOL OF THE DASIS OF	examination an	e, death oc	curred at the ti	me, date and pla ppinion, death or	ace, and due to the courred at the time	e cause(s) o, date and	and manner as splace, and due to	stated. o the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	29b. S	Signature and titl	le of certifier	000								

State Registrar

Division of Vital Records, P.O. Box 68760,

Criffin Arthur Edwards

Thomas Hansson, MD 31. Date filed (Month, Day, Year) AUG 1 6 2005 8118 Goodluck Road

22. Registrar's Signature Lanham Md 20106

State of Maryland / Department of Health and Mental Hygien 2005

28399

							Cen	rificate	e or	Death			Reg. No.		
			1. Decedent's Name (First, Middle	e, Last)								2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medica		GEORGE ALO	NZO F	ERG	USON	JR.					August		2005	2:00AM
4	Examine		4a Facility Name (If not institution			0.0011	01,			4b. City, To	own, or Lo	cation of Deat	h 4c. Count	y of Death	
1			5307 Al-Jones	Drive						Shad	v Sid	ie ei	Anne	Arund	el
	Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. last bin	hday)	If Under		If Under	24 Hrs.	8. Date of Bi			e (State or Foreign
	Director		578-16-7691	1 🖾 M 2 🗆 F		82	Yrs.	Months	Days	Hours	Min.	May 25	, 1923	Washi	ngton, DC
		ı	Usual Residence of Decedent				1						, 1,20		ngoon, be
	/lanc		10a. State 10b. County			10c. City, Town	or Loc	ation						10d	Inside City Limits
	Man Man	ខ្ន	Maryland Anne	Arundel		Shad	v Si	de							1 X Yes 2 ☐ No
	288 Inc.	ည်	10e. Street and Number				,	10f. Zip	Code				10g. Citizen of	What Country	7
	with page 1	Ē	5307 A1-Jones	Davi es a				21	0764	<i>t</i> .				USA	
	1 and 2 should be filled within 72 hours after death with the Maryland Health and Mental Hygiene.  em 27 is marked other than "netural; or items 23a or 28a-f show other traumatic event, it is Medical Example must be notified at	l o Be Completed by Funeral Director	11. Marital Status	12. Was Dec	edent l	Ever in U.S.	13. W				igin? (Spe	ecify Yes or No	- 14 Ra	ce - American	Indian.
_	iter d	5	1 Never Married 2 Marr	Armed F	orces?		If	Yes, speci	ify Cuba	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	Bla	nck, White, etc. Afri	
20	rs af	چ	3 ☐ Widowed 4 ☒ Divorced	If Yes G	ive	`11 <b>-</b> 9-42		☐ Yes 2	No	Specify.			Speci	tv:	
Maryland 21215-0020	hou hou	<u> </u>	15. Decedent		Julius.	4-28-43		nt's Usual	Occur	nation			16h Kind of F	Business/Indus	ican
5	"ne	ē	(Specify only highes	st grade completed,	)		(Give k	ind of work	k done	during mos	t of worki	ing	TOD: KING OF	703111033/111003	nt y
12	withi	티	Elementary/Secondary (0-12)	College	(1-4or 5	+)				z Sicist			Cov	ernment	_
7	iled the spirit	3	17. Father's Name (First, Middle,	5+		1	1 ucı	ear r	пуз			(Firet Middle	, Maiden Suma		
ž	data h	8 2				-						-		,,,,,	
ž	Mer Mer Mer Mer Mer Mer Mer Mer Mer Mer	2	George Alona		gus	on Si	·			Maı	ry	_ь	Burden		
<u>a</u>	2 sh end is m		19a. Informant's Name/Relations		III	19b.	Mailing	Address	(Street	and Numb	er or Rura	al Route Numb	er, City or Town	i, State, Zip Co	<sup>ode)</sup> 22041
	and saith n 27 ier ti		George Alonzo Fe	erguson (	Son	) 370	)1 S	. Geo	orge	e Masc	on Dr		5N Fall		
Ze	S = 5		20a. Method of Disposition 1 □ Burial 2 X Cremation	0	C1-1-	20b. Place of cem <i>eter</i>	Dispos y, crema	ition (Nam atory or oti	e of her plac	ce)	i	Date	20c. Location	- City or Town	, State
Ĕ	Pages nent of I		4 □ Donation 5 □ Other (S)	з шнетоval from pec <i>ify)</i>	State						rv S	-16-05	Riverd	ale M	D
Baltimore,	표 된 된 글 .	ŀ	21. Signature of Funeral Service	Licensee						ss of Facili	de a				
m	Depa Impo any i			1/1			100	11 71					uneral S		
		4	220 Part Esign disease			the death. Do a	400	)T Be	nnıı	ng Ko	ad, I	NE Wasi	ington,		0019 oproximate
н			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each lir	ne death. Do r ne.	iot erite	the mode	or uyır	ig, such as	Cardiac	n respiratory a	iriesi,	ln'	terval Between nset and Death
ş	Physician														niset and Death
1 .	/Medical Examiner		Immediate Cause (Final disease or condition	a Card	iopi	ulmonary	ar	rest							
			resulting in death)	•		Due to (or as a	onsequ	ence of):						1	
	D # 5	Examiner		_ h Meta	stat	tic pros	tat	e can	icer						
	acute trans	E	Sequentially list conditions,			Due to (or as a c									
Ö,	e exa		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Blad	der	cancer								1	
376	ate b nysic he b	28	that initiated events resulting in death) Last	C		Due to (or as a c	onsequ	ence of):							
ox 68760,	The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be deteched for use as the buriel-transit	rnysician/medical													
	endir r use	2	·	d	-	-									
Ω.	res thet the death signed by the atte I be deteched for	<u> </u>	Part II. Othar significant conditio	ns contributing to d	leath bu	ıt not resultina in	the und	derlying ca	use giv	en in Part	l.	23b. Did	tobacco usa co	ontribute to th	e cause of death?
P.0	t the											1□	Yes 2 No	3 ☐ Probab	dy 4 □ Unknown
	thed lead lead	y y											44000		,
Records,	uires Id ba	2										24a. Was	an autopsy	24b. Were	autopsy findings
ĕ	v require been sig should t	Completed										perfo	med?	comp	ble prior to letion of cause
ě	has ge 2	림											22.7	of dea	itn?
=		5										**	Vae 2X No	1 🗆 Y	es 2□ No
Vital	certificate	9	25. Was case referred to medical examiner?						W 77577		of Death	(Check only o	one)		
<del>6</del>	\$ 0 E	0	1 ☐ Yes 2 🐧 No	Hospital: 1 □	Inpatie	nt 2 ER/Out	patient	3□ DO/	A Oth	er: 4□ Nu	rsing Hor	ne 5 <b>∑</b> Resi	dence 6 □Ot	ner (Specify)	
0	Jing Ph h. After th funeral	<u> </u>	27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mor	of Injur	y Year) 28b. T	ime of	28	Bc. Injur Wor	y at k?	2	28d. Describe	how injury occu	rred	
0	ath. r: Af		2 ☐ Accident investig	ation			,	M		Yes 2	No				
Division	l or Attending after death. Director: After I in by the fune	2	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 200. Flau	e of Inju	ry - At home, fai	m, stree	et, factory.	office		- 2	28f. Location ( City or To	Street and Num	ber or Rural R	oute Number,
Ö	tal or Attending P rs after death. el Director: After t led in by the funer.	5	4 🗆 Normoide	build	ing, etc	. (Specify)						Ony or 10	WII, State)		
	Hospital Punerei Funerei Itely filled		29a. Certifier 1 Certifyin	g Physician: To the	best o	f my knowledge,	death o	occurred a	t the tin	ne, date en	d place, a	and due to the	cause(s) and m	anner es state	d.
	P Ho 24 h	ag lea	(Check only 2 Medical I	Examiner: On the band man	asis of ner sta	examination and ted.	Vor inve	stigation, i	in my o	pinion, dea	th occurre	ed at the time,	date and place,	and due to the	e cause(s)
		Ξ	29b. Signature and title of certifier					29c.	Licens	e number			29d. Date signe	ed (Month, Day	v, Year)
	H \$ H 0		1. 1.	01		+ 7	. 1		1//	3111			noli	5/20	05
1	0111		Thelly	y Pro	ec	LOU M			6	741	_		0811	5/20	03
21	20/11/2		30. Name and address of person v	0				•							
4	IN		Phillip J. Proc	tor, MD	116	0 Varnu	m St	reet	. N	E Was	ching	gton,_D	C = 2001	7	
	State	-	31. Date filed (Month, Day, Year)	กกร 🎉	negistra	r's Signature	Land	20							
	Registra		AUG 1 6 2	000	w	N 19									

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien \( \Omega \) \( \Omega \)

	_		-	-
2	0	4	п	n
	O	4	U	u

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H ertificate of L	leaith and iv D <i>eath</i>		len <b>2</b> 0 0 5	28400
	Physici		Decedent's Name (First, Middle  Lewis	o, Last) Owens		Gullette		2. Date of Deat Month August	h Day Year 14 2005	3. Time of Death 7:15A
}	/Medic Examir		4a. Facility Name (If not institution				Location of Death	August	4c. County of Deat	
			1922 Church C	reek Road		Church	Creek		Dorches	ter
	Funeral		5. Social Security Number		e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	year) 9. Birt	hplace (State or Foreign
	Director		214-07-8214	120 M 2 L F	91 Yrs.	Wionals Days	l louis louis.	Nov. 2,	1913 Ma	ryland
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
$\neg$	Maryli f aho	or		hester	Too. Only, Town of E		h Creek			1 Yes 2 □ No
7	the 28a-	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co	untry?
2	th with		1922 Church	Creek Road			21622		USA	,
21215-0036 V C	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, I'v. Medical Examinative Locified at Once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	If Voc Give		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🗷 No		ecify Yes or No- Rican, etc.)	14. Race · Ame Black, White Specify: W	
Š O	72 ho	Completed	15. Deceden (Specify only higher	t's Education	16a. Dece	ident's Usual Occupa	ation	ing	16b. Kind of Business/	Industry
2	ithin nan "	nple	Elementary/Secondary (0-12)	College (1-4or	o+)	e kind of work done o DO NOT use retired,		ng		
2	filed w Hygier ther th	So	11	2		<i>r</i> ice presi			food proc	essing
and	be fi	Be	17. Father's Name (First, Middle,  Joseph Augus	•	3		18. Mother's Name	Mae Lew.	,	
3	should ind Men ind marke imaric	은								
Maryland	d 2 sho th and th sma traums		19a. Informant's Name/Relations E. Anne Gullet						City or Town, State, Z h Creek, M	
	1 and Health tem 27 other tr		20a. Method of Disposition	ice daugin		osition (Name of matory or other place			20c. Location - City or	
Baltimore,	Pages nent of int: If it		1 Surial 2 □ Cremation 4 □ Donation 5 □ Other (S			matory or other place Lty Church	,		Church Cre	
======================================	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service			2. Name and Addres			eral Home	
ñ	Depa Impo any it		Brun k. Br		Hos	700 Locust				8
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	-a. ASP1	/	ter the mode of dying	•	or respiratory arre	est,	Approximate Interval Between Onset and Death
	. 1	<u>.</u>	Sequentially list conditions,	b. — Due to (or as	a consequence of):					
	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (01 23	a consequence or,					
a,	rtificate be executed to physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
09/89	ite be iysicia ne bur	ledical		d						
O. Box 68	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
ecords, P	as this	by	Part II. Other significant condition	ons contributing to death b	ut not resulting in the c	ınderlying cause give	on in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Ö	w require been significations	etec	Acres	161	21,30420			-		
r	The ate h page	Completed	1100 Me	na ( 141/U	176			24a. Was ar autopsy perform 1 Yes 2	prior to c	topsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?			011	26. Place of Death			
0	Physic this c	2	1 Tes 2 ONo		ent 2 ER/Outpatie				nce 6 Other (Spec	eify)
	ling After une	tlon:	27. Manner of Tath  1 Alaturai 5 ☐ Pendin 2 Accident investig	g 28a. Date of Inju (Month, Da	y Year) 28b. Time o	Work		28d. Describe ho	w injury occurred	
DIVISION	al or Attending s after death. Il Director: After d in by the fune	Certification:	3 Suicide 6 Could in determine	not be 200 Place of Ini	ury - At home, farm, st c. (Specify)			28f. Location (Str City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier Certifyin (Check only one)	g Physician: To the best Examiner: On the basis o and manner sta	f examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th withir To th comp	ž	29b. Signature and title of certifier	11		29c. License	number	29	d. Date signed (Month	, Day, Year)
			Uryene, 1	Venno Z		H5	1793		8/15/05	
			30. Name and address of person	who completed cause of d	eath (Item 23a) (Type,	Print)	ot Ca	mbrid	In MO	2/6/3
	Sta Registr		31. Date filed (Month, Day, Year)	1 7 2003 Registr	ar's Signature	Sports		/		

			1 - For Stata Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of rtificate o	f Health i of Death	and M	ental Hygi	en 200	5	281	101
	Dhysisi		1. Decedent's Name (First, Middle, Last)						2. Date of Death Month		Year	3. Time o	
	Physici /Medio			Genau					August	11, 200		6:15	Рм
	Examir	er	4a. Facility Name (If not institution, give s.	treet and number)			n, or Location			4c. County o			
			124 Quincy St.  5. Social Security Number 6. Sex	7 40	e (In yrs. last birthday)	Chev	-		0. Data of Birth	Montgo			
	Funeral Director			M 2 🕸 F	99 Yrs.	Months Da		Min.	8. Date of Birth (Month, Day, Apr. 11,	1906	Goun	lace (State : try) .nois	ər i-oraign
	מ		Usual Residence of Decedent										
	arylan show	_	10a. State 10b. County		10c. City, Town or Lo						1	Od. Inside C	•
	88e-f	ecto	Md. Montgome	ry	Che	vy Chas							2 □ No
	with ti	Dire	10e. Street and Number 124 Quincy Stree	+		10f. Zip Cod	e 20815		10	g. Citizen of Wh USA		itry?	
	be filed within 72 hours after death with the Maryland ital Hygiene. In the meturel, or items 23e or 28e-f show event, the Modical Examinat must be notified at	Funeral Director		2. Was Decedent	Ever in U.S. 13. \			igin? (Spe	cify Yes or No-	14. Race		an Indian	
က	ifter o	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔼 I	No I				cify Yes or No- Rican, etc.)	Black	, White,	etc.	
ğ	rel', o	by	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		1∐ Yes 2⊠ I	No Specify:	:		Specify:	Whit	e	
21215-0036	72 h "netu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Oc kind of work do	ne during mos	st of workir	ng 10	6b. Kind of Bus	iness/Ind	dustry	
12	within ane. then	mp	Elementary/Secondary (0-12)	Coflege (1-4or 5	54)	<i>DO NOT</i> us <i>e re</i> l istrati	,	istar	nt	March	of D	imes	
р 2	filed Hygie other		17. Father's Name (First, Middle, Last)						(First, Middle, Ma				
au	lid be lental ked c	To Be	Owen Houlihan				No	ra W	Vah1				
Maryland	should and N	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maifir	ng Address (Stre	et and Numb	er or Rura	Route Number,	City or Town, S	tate, Zip	Code)	
Σ	and 2 salth n 27 i		Joan Marie Sharia	t/Daughte				, Che	vy Chase	e, Md.	2081	5	
altimore,	jes 1 of He if iten or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re	emoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other)	olace)	Aug. 1	ate 20	c. Location - C	ity or To	wn, State	
Ē	. Pag tment tent: jury c		' 4 ☐ Donation 5 ☐ Other (Specify)		Mt. Olive			2005		ashingt		D.C.	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, Ire Modical Examiner must be notified at once.		21. Signature of Funeral Service Liberse	Fort	22	. Name and Ad	dress of Facili 222 Was	2 Wishingt	ol Funer sconsin A con, D.C.	Ave N 20007	.W.		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused e cause on each li	the death. Do not ent	er the mode of	dying, such as	cardiac or	r respiratory arres	t,		Approximat Interval Bet	tween
H	Physician		Immediate Cause (Final disease or condition	Arterio	sclerotic	Cardiov	ascula	r Dis	ease			Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								
h	30	-	Sequentially list conditions, if any leading to immediate		a consequence of):						-		
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	220 10 (0. 22	2 331133 4351733 317.								
Ć,	exection and items of the section and the sect	Еха	resulting in death) Last	Due to (or as	a consequence of):						_		-
8760,	rcate be executed physician and the burial-transit	dlcal	d.										
9	ntifica ing ph a as th	a)	IF FEMALE:										
Вох	death certific e attending p d for use as	by Physiclan/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregna				23d. Date Monti			Year
0	0 0 0	ysic	1 ☐ Yes 2 █️No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5 [_	Other (specify)				9	,	July	1041
٥.	The law requires that the ste has been signed by the page 2 should be detache	/ Ph	Part II. Other significant conditions cont	ributing to death b	ut not resulting in the ur	nderlying cause	given in Part I	l.	23e. Did toba	cco use contrib	ute to th	e cause of c	death?
ds	quires n sign								1 ☐ Yes	2 <b>™</b> No 3	☐ Proba	ably 4 🗆	Jnknown
Records,	aw requir s been si 2 should b	Completed							24a. Was an	24b. We	ere autop	sy findings	available
Ä	The lavate has	mo							autopsy performe	de:	or to con ath? ] Yes	npletion of c 2 □ No	ause of
Vital		BeC	25. Was case referred to medical examiner?				26. Place	of Death	Check on one	5140		2	
× ×	d is	10	1 ☐ Yes 2 ☐ No	ospital: 1 🗌 Inpatie	ent 2 ER/Outpatien	t 3 DOA	Other: 4 🗆 Nu	ursing Hom	ne 5∐XResiden	ce 6 □Other	(Specify	)	
Division of	ding Ph h. After th funeral	on:	27. Manner of Death  1 Autural 5 Pending	28a. Date of Inju (Month, Day		V	liury at Vork?		8d. Describe how	injury occurred	t		
Sic	Attend er death ector: / by the f	icati	2 Accident investigation 3 Suicide 6 Could not be	One Disea of lai	una Athama fassa sta		☐Yes 2☐		Of Lanation (Care	-4 d &b b		D	,
2	l or A after Direction by	Certification:	4 Homicide determined	building, et	ury - At home, farm, stre c. (Specify)	eet, factory, offic	00	4	8f. Location (Stre City or Town,		or Hurai	HOUTE NUM	Der,
	spite nours nerel		29a. Certifier 1 Certifying Physi	ician: To the best	of my knowledge, death	occurred at the	time, date an	nd place, a	nd due to the cau	se(s) and mann	ner as sta	ated.	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Examination)	er: On the basis of and manner sta	examination and/or inv	estigation, in m	y opinion, dea	th occurre	d at the time, date	e and place, an	d due to	the cause(s	)
	To the To the Comp	M	29b. Signature and title of certifier	16		29c. Lice	ense number		290	I. Date signed (	Month, L	Day, Year)	
. ,			Colet	1/20	e ps		009317			August	12,	2005	
K	(6)		30. Name an address of person who com										
			Robert F. Byrne, N 31. Date filed (Month, Day, Year)		3 S. Nash	Street,	Arling	gton,	Va. 222	.02			
	Sta Registr		AUG 1 6 2005		A Speed	الع							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

			se Type or Prir									
		1 - State Amend Item Registrar	1&Unpend It	aryland/[ em 23a,	2epa	adment of bearing and the contract of the cont	leaith and N <b>me G847</b> Death	lental Hydig	age 20 (	05 2840		
		1. Decedent's Name (First, Middle,						2. Date of Death		3. Time of Death		
sicia. edica		STEPHANIE MIC	HELLE HUBBA	RD				Month August		9:08 A M		
mine		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of Death		4c. County of			
		5716 Plata Stree	t			Clinton			Prince	George's		
ral or		5. Social Security Number  578 94 9118  Usual Residence of Decedent	6. Sex 7. Aga 1 ☐ M XXF	e (In yrs. last bir 40	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear)	Birthplace (State or Foreign Country) WASHINGTON, D		
		10a. State 10b. County		10c. City, Town	n or Lo	cation				10d. Inside City Limits		
SDCC.	0	MARYLAND PRINCE	E GEORGES	CITNTC	\ T.F.(					XIX Yes 2 □ No		
	Director	10e. Street and Number	E GEORGES	CLINTO	)IN	10f. Zip Code		100	Citizen of Who			
		E716 DIAMA GEDER	D.M.			Ton. Elp occu		100	10g. Citizen of What Country?			
	runerai	5716 PLATA STRE	ET 12. Was Decedent I	Ever in U.S.	13 \	Nas Decedent of H	20735 ispanic Origin? (Spe	noify Vas as No		STATES		
	5	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?		13.	f Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, V	American Indian, Vhite, etc.		
	2	3 ☐ Widowed XX Divorced	If Yes, Give Year or Dates:	••		1□Yes 💥 🗓 No	Specify:		Specify:	BLACK		
3	2	15. Decedent's	Education	16a.	Deced	ient's Usual Occup	ation	16	b. Kind of Busin			
1	5	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5		(Give	kind of work done of NOT use retired	during most of worki	ng i	o. rand or bushi	essanidustry		
	12TH LEGAL SECRETARY  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Ma								PRIVATE			
F	2	DAVID EDWARD BRO	OADY				CAROLYN	CARTER				
ľ		19a. Informant's Name/Relationship	p (Type, Print)	19b.	Mailin	g Address (Street	and Number or Rum		ity or Town, Sta	te. Zip Code)		
		SOPHIA ELLISON /	/ DAUGHTER			PLATA ST		LINTON, M				
		20a. Method of Disposition		20b. Place of	Dispo	sition (Name of	· D		c. Location - City	or Town, State		
		XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				natory or other place			•			
	1	21. Signature of Furreral Service Lie		HARMON	22	.EMOKIAL .  Name and Addres	PARK 08/19	9/2005	LANDOVE	R, MD		
		21. Signature of Funenal Service Licensee  22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, I 4308 SUITLAND ROAD SUITLAND, MD 207  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
		23a. Part1. Ehter the disease, or co shock or heart failure. List on	emplications that caused nly one cause on each lin	the death. Do n	ot ente	er the mode of dyin	g, such as cardiac o	r respiratory arrest		Approximate Interval Between		
Ŷ.	1	Immediate Cause (Final disease or condition	Seizure	Disorde	r					Onset and Death		
ı	1	resulting in death)	Due to (or as a	a consequence o	of):							
ı		Sequentially list conditions	b									
Fyaminer	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence o	of):							
8	3	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
		resulting in death) Last	Due to (or as a	a consequence o	of):							
100	•		d									
Physician/Media	3	IE EENALE							1			
2		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy	2□	Catania assauss			23d. Date of	delivery		
2		in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No  4 Pregnant at time of death 5 Other (specify)								Day Year		
2		9 <b>⊠U</b> nknown 9 Unknown										
200									d tobacco use contribute to the cause of death?			
									Probably 4 Unknown			
Completed								24a. Was an	24h Were	autoney findings available		
E SE								autopsy performed	prior 1? death	autopsy findings available to completion of cause of		
CO		25. Was case referred to modical						1) Yes 2	No 1 🖎	es 2□ No		
0 86		25. Was case referred to medical examiner?	Hospital:		- 1		26. Place of Death					
۱ř	+	1 SY'es 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE										

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completaly filled in by the funeral director, paga 2 should be detached for use as the buria-trar Division of Vital Records, P.O. Box 68760,

Priya /Me Exam

Certification: To

27. Manner of Death

1 Natural 2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

29a. Certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 XNo

29d. Date signed (Month, Day, Year)

28d. Describe how injury accurred Subject Was In Vehicle Struck By A Fire Truck

28f. Location (Street and Number or Rural Route Number, City or Town, State) **unk** 

OCME

August 15, 2005

5 Pending investigation

6 Could not be determined

31. Date filed (Month, Day, Year) AUG 2 4 2005

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

Roadway

111 Penn Street, Baltimore, Maryland 21201

Other: 4 Nursing Home 5 Residence 6 XOther (Specify) SCENE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of **unk** 28c. Injury at Work?

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Cedric Gregory Howard 09 10:10 P<sup>M</sup> 2005l /Medical August 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13 Watkins Park Drive Mitchellville Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10M 20F Director 217-11-0964 23 05/19/1982 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f ehow 10d. Inside City Limits MD Director P.G. Upper Marlboro XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Watkins Park Drive 20774 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Exercitives m 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married ŏ Maryland 21215-0036 1 ☐ Yes 2☐√No Specify Specify: 3 Widowed 4 Divorced Black natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 ie marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 12th Warehouse Shipper Safeway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cedric Gregory Howard, Sr. Claudia Fountain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Claudia L. Howard - Mother 19 Watkins Park Drive; Upper Marlboro, MD Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Peges nent of I 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Pege Depertment of Importent: if eny injury or Riverdale Crematory 8/17/2005 Riverdale, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signal of uneral Service Licenses P.O. Box 416; Suitland, Maryland 20752 Part1. Enter the disease, or conshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple quishot
Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death P.O. I 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ sign 1 be should 1 🗌 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? certificate 1 Yes 2 □ No 2 No Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence  $_{6}$  MOther (Specify) at scene Hospital: ۵ 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. subject Shot investigation 21:44 1 ☐ Yes 2 No 2 Accident the within 24 hours after deat To the Funerel Director: 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 10, 2005 30. Name and address of person who completed cause of yearth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State AUG 1 6 2005

Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5

28	4	0	4
----	---	---	---

		•	1- For State of Maryland / Depart	ificate of Death		eg. No.	20404
			Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death
	Physicia /Medic		<u> Eunicelee</u> Elizabeth Hupke		allig.	10 2005	- 1644 M
	Examin	er	4a. Facility Name (If not institution, give street and number) PENSINSULA REGILINAL MANICAL CONTUR	4b. City, Town, or Location of Death	V	4c. County of Deat	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min.	8. Date of Birth	9. Birt	hplace (State or Foreign untry)
	Director		218-05-8959   10 M 2 M F   85 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day 1/25/19	20 Ma	ryland
	land ow	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	ation			10d. Inside City Limits
	a-feh	tor	Maryland Wicomico Salisbu	ry			1 X Yes 2 ☐ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	1	Og. Citizen of What Co	untry?
	eath w	Funeral Director	1217 fredrick Ave.  11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	21801 as Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - Ame	rican Indian,
130	be filed within 72 hours after death with the Maryland tal Hyglene.  al Hyglene do the than "natural", or items 23a or 28a-f ehow other than "natural", or items 23a or 28a-f ehow event, I're Medical Examiner constitued at	by Fun	1 □ Never Married 2 □ Married 1 □ Yes 2X No	as Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto Yes 26 No Specify:	Rican, etc.)	Black, White Specify: wh	
2-003p	72 hor	eted	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	nt's Usual Occupation ind of work done during most of work O NOT use retired)	ing	16b. Kind of Business/	Industry
Z	within ane. than "	Completed	Elementary/Secondary (0-12) College (1-40r 5+)			Domestic	
N 0	illed Hygie other ent, II	a)	12 - HOmem  17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, i	Maiden Sumame)	
yland	should be nd Mental marked c	ToB	Levin Washburn	Mary Ma	artin		
Mar	12 sho			Address (Street and Number or Rur			
	Healt Healt tem 2		Sharon Peterman/daughter 4416  20a. Method of Disposition 20b. Place of Disposition cemetery, creme	Coulbourn Mill Ro		20c. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 ie marked any injury or other traumatic evones.		'4 □ Donation 5 □ Other (Specify) Wicomico N	Memorial 8/15		Salisbury,	
g R	Depa impo any ir once		MONICO PROPOSONO CESP 50	Name and Address of Facility Lloway Funeral Ho 1 Snow Hill Rd.,	Salisbu	ry, MD 218	04
			23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	hemin			
	Examiner		act was	- Truck m	restin		
L.,	be tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	10. 101:11	15.		
	rificate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c	strul form	Y 400 .		
8/60	ysiciar ysiciar te buri	edlcal	Corney on	to drive			
٥	E CO CE	Med	IF FEMALE:				
X R R	eath cert attendin I for use	Physician/M	23b. Was decedent pregnant in the past 12 pronths?	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
o <u>i</u>	the de	hyslo	1 Yes 2 No 9 Unknown 9 Unknown	Strot (apoonly)			
JS, P	The law requires that the death ce tte has been signed by the attendi bage 2 should be detached for use	þ	Part II. Other significant conditions contributing to death but not resylting in the unc	lerlying cause given in Part I.	23e. Did to	bacco use contribute to es 2⊠No 3□Pr	the cause of death?
ecords,	w requ	letec	Horon trus		24a. Was a		itopsy findings available
Y	The lav	Completed			autops	med3 prior to death?	completion of cause of
Vita	eician: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Deat			
ot	Phyei this c	. To	1 ☐ Yes 2 📉 No Hospital: 1 🗹 Inpatient 2 ☐ ER/Outpatient			ence 6 Other (Spe	cify)
0	nding P th. : After e funer	atlon	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	28c. Injury at Work?  M 1 Tes 2 No		,.,	
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Si City or Town	treet and Number or Ru n, State)	ıral Route Number,
	To the Hospital or I within 24 hours after To the Funeral Directorpletely filled in b		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place.	and due to the c	ause(s) and manner as	stated.
	the Ho in 24 I the Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or invented and mappier stated.				
	10 V V V V V V V V V V V V V V V V V V V	Σ	29b. Signature and title of certifier	29c. License number	. 2	8/10/05	n, Day, Year)
	Ea		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint) St. Salishum			
	(S)	10	31. Date filed (Month, Day, Year) 32. Posistrar's Signature	SI SHIIS BURN	mes	,	
	Sta Registı		AUG 1 5 2005 Brokers & Co	artis			

Myke, Euricelee 218-05-8959

State of Maryland / Department of Health and Mental Hygien 28405 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8/11/2005 **Physician** Willard Thomas Jackson Sr. /Medical 9:15 p M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sud1ersville Queen Anne's 825 Stulltown Road If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06/13/1911 Birthplace (State or Foreign Country) **Funeral** 94 Yrs Director 217-36-0806 MĎ Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturet; or Items 23e or 28e-1 show eny injury or other treumetic event, If a Mudical Examiner must be negative once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Queen Anne's Sudlersville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21668 USA Be Completed by Funeral 825 Stulltown Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farming Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey A. Jackson Julia Ann Hay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willard Jackson Jr./Son 610 Race Track Road Sudlersville, MD 21668 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State Sudlersville Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 8/16/2005 Sudlersville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St Millington, MD 21651 pson 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterio Scherotic Cardio Vascular Disease Physician Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hx Colon CA; Hx Stomach Tumor; 1 ☐ Yes 2 🕱 No 3 Probably 4 □Unknown Completed Hx SKINCA: HX HT 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) ဂ္ဂ 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D (certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50996 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Stoddard, M.D. 100 Brown St. Chestertown, MD AUG 1 6 2005 31. Date filed (Month, 32. Posistrar's Signature State Registrar

			1 - State Carter S	of Maryland / Depa <i>Cer</i>	artment of H tificate of L	ealth and N Death			
Е	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month August		3. Time of Death
	/Medic	al	Andrew William Jordan  4a. Facility Name (If not institution, give street and no	umbar)	4h Cihi Toum or	Location of Death	August	4c. County of De	
	Examin	er	1st Unit Block Moore Roa		Conowing			Cecil	aut
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	if Under 24 Hrs.	8. Date of Birth	9. B	irthplace (State or Foreign
	Director		222-60-9154 <sup>1</sup> ∑M 2□F	25 Yrs.	Months Days	Hours Min.	Oct. 30	, 1979	irthplace (State or Foreign Country) Delaware
	pu 🔉		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	f eho	ŏ	Maryland Cecil	Port De					1 □Yes 2 🔯 No
	28a-	Director	10e. Street and Number	TOIL DE	10f. Zip Code			10g. Citizen of What (	Country?
	h with	O le	46 Bullet Street			21904		USA	
	- deat	Funeral	11. Marital Status 12. Was De Armed F	cedent Ever in U.S. 13. Vorces?	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Race - An Black, Wi	nerican Indian, nite, etc.
36	s afte	by Fu	If Yes, G	2 XNo live	1 ☐ Yes 2 💢 No	Specify:		Consitu	)hite
8	ture!	ed b	3 ☐ Widowed 4 M Divorced Year or  15. Decedent's Education	16a Decer	dent's Usual Occupa	ation	1	16b. Kind of Busines	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or fleme 23a or 28a-f ehow the Madical Examiner must be notified at	Completed	(Specify only highest grade completed	(Give (1-4or 5+)	kind of work done of DO NOT use retired	during most of world  )	king		,
7	or the	Com	1		Mechanic			Heating &	Air Cond.
g	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
Maryland	d Men	٦ ک	James Andrew Jordan, S  19a. Informant's Name/Relationship (Type, Print)		a Address /Street		Lee Woh	NCT or, City or Town, State	Zin Code)
<u>S</u>	d 2 st th and t7 te r		Sharon Lee Jordan/Moth					it. MD 219	
<u>6</u>	Heal Hem		20a. Method of Disposition	20b. Place of Dispo			Date 5-2005	20c. Location - City	
Ë	Page: lent o nt: If i		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	R. T. Foo				Risina Sun	, Maryland
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Iteme 23a or 28a-f show suppringing or other treumatic event, the Madical Examinat must be notified at ance in jury or other treumatic event, the Madical Examination at ances.		21. Signature of Funeral Serves Licensee					D A	, ,
<u></u>	89629		The state of		1 S. Que	en St., k	Pising S	P.A. un, MD 219	11
			23a Part1. Enter the disease, or complications that shock, or hear failure. List only one cause on	caused the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Hanging					
	Examiner		Due to	o (or as a consequence of):					
		Jer		o (or as a consequence of):					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
Ö,	e exe	i Ex	resulting in death) Last Due to	o (or as a consequence of):					
68760,	icate be executed physicien and s the burial-transit	dlcai	d						
			IF FEMALE: 23c. If yes, o	utcome of pregnancy				23d. Date of d	elivery
Вох	death a atter d for u	Physician/M	1 Ves 2 No 4 Pred	gnant at time of death 5	Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	by the	hys	9 ☐ Unknown 9 ☐ Unk	nown			-		
	law requires thet the death certifes been signed by the attending as should be detached for use as	þ	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
ord	w require been si should i	ted			-		101	'es 2 □ No 3 □	. 1)
3ec	e law hesb je 2 sl	Completed					24a. Was a autop perfor	an 24b. Were prior to med? death	autopsy findings available completion of cause of
a E	n: Th licate r, pag						1 ☐ Yes	2 No 1 □ Y	
Division of Vital Records,	siclar s certificacto	To Be	25. Was case referred to medical examiner? 1	Inpatient 2 ER/Outpatien	nt 3 DOA Othe	er: 4 Nursing H		<i>ne)</i> lence 6 ⊋Other (St	ocify) - b
1 0	g Phy er this		27. Manner of Death 28a. Date	e of Injury onth, Day Year) 28b. Time of Injury				now injury occurred	at scene
ior	endin sath. or: Aft	atlo	2 ☐ Accident investigation	1011-61	46Hours	Yes 2 No	Julye	though	sey
ξ	frer de lirecte n by t	Certification:	3 Suicide 6 Could not be determined 28e. Place	ce of Injury - At home, farm, str ding, etc. (Specify)			28f. Location (S City or Tow	Street and Number or m, State) First	Aural Aouse Number. umt Black of
	pltat ours all		29a. Certifier 1 ☐ Certifying Physician: To the	power to	h accurred at the tim	no, date and place	Moor a Rose	d, Comewings	Montand
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical	(Check only XX Medical Exeminer: On the						
	To the To the	Me	29b. Signature and title of certifier		29c. License			29d. Date signed (Mo	nth, Day, Year)
			Theologe U. N	ing mus	O.C.M	1.E.		August 13	, 2005
	5		30. Name and address of person who completed ca			root Pol	tiomore	Mazzzland	21201
			31. Date filed (Month, Day, Year) 32.		reini ott	.cet, Dal	crollore,	Maryland	414UI
	Sta Registi		AUG 1 6 2005	Registrar's Signature					

			For State Registrar	State of Mai	yland / D	epartment of I Certificate of	Health and M Death		giene 200	15 28407
	hysicia /Medic		1. Decedent's Name (First, Middle, Last) Shinley F Klompus					2. Date of De Month	Day Y	3. Time of Death 2:20 pm
Fu Dir	xamin neral ector	er	4a. Facility Name (If not institution, give to the Ster River  5. Social Security Number  6. Sex 15 14 7758  Usual Residence of Decedent  10a. State 10b. County	G hu 7  A ge 7. Age	In yrs. last birth	Chester (Inday) If Under 1 Year Months Days	or Location of Death  or N  If Under 24 Hrs.  Hours Min.	8. Date of Bir (Month, Da	th y, Year)	I. Birthplace (State or Foreign Country) NY  10d. Inside City Limits
ith the Mar	or 28a-1 si se notified	Director	MD Anne At	rundel	Annapo	10f. Zip Code	/ O.1		10g. Citizen of Wh	1 ☑ Yes 2 ☐ No at Country?
aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene.	marked other than "natural, or itame 23s or 28s-1 show imatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 ঐNo If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of If Yes, specify Cut		pecify Yes or No Rican, etc.)	USA 14. Race - Black, Specify:	American Indian, White, etc. White
21215-0036 Id within 72 hours af giene.	r than "nature tra Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+ 5+		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Teacher/Gui	during most of world)		16b. Kind of Busin	,
Maryland d 2 should be filed th and Mental Hyg	rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Morris Kline					ne (First, Middle Price	, Maiden Sumame)	
₹ 5 E	9 8		19a. Informant's Name/Relationship (Ty Marilyn Klompus/I			Mailing Address (Stree 87 Alice Ct			-	ate, Zip Code)
Baltimore, M bermit. Pages 1 and 2 Department of Health	int: If item iry or other		20a. Method of Disposition  1 ≅ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of cemetery	Disposition (Name of c, crematory or other pla Park Cemete	ace)	Date 4/2005	20c. Location - Ci	ty or Town, State  New York
Balt permit. Departn	Important: If its any injury or o once.		21. Signature of Funeral Service Licens	Pelky	1	22. Name and Addr Fellows	ess of Facility Helfenber Road Cl	ein & Ne	ewnam Func	eral Home
Me Example of executed	physician and dical fransit site prival-transit	dicai Examiner	23a. Part1. Enter the disease, or complisheck, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, the conditions of the cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a Due to (or as a d.	consequence of	ot enter the mode of dy  f):	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Box 6	by the attending parached for use as	Physician/Me	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	зу		23d. Date of Month	,
	been signed b	by	Part II. Other significant conditions con	exb-Sinc	not resulting in	the underlying cause g	ven in Part I.	1 🗆	Yes 2.2170 3	ute to the cause of death?
I Rec	has je 2	Completed						24a. Was auto perfo 1 \( \text{Yes} \)	psy prid prmed? dea	re autopsy findings available or to completion of cause of ath?  Yes 2 1000
of Vita Physician:	is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital:	2 ☐ ER/Out	patient 3 DOA	26. Place of Dea		one) dence 6 □Other	(Specify)
S gilling	After th funeral	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. T	ime of 28c. Injury Wo			how injury occurred	
DIVIS	al Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.		m, street, factory, office		28f. Location ( City or To		or Rural Route Number.
	To the Funeral Dir completely filled in	Medical			xamination and	death occurred at the to for investigation, in my				
To the within 2	To the	ž	29b. Signature and title of contriber	$0 \leq 1$		1	se number		29d. Date signed (	Month, Day, Year)
			MICHARD FFIN	omplet d use of dea	1225K	Type, Print Zn RD, S	00603 IES CL	प्रस्टेडिस १	2 Pour,	mJ 21670
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 2 2	32. Registrar	s Signature	AND				

DHMH 17 Rev 1/2001

			State of Maryland / Depa	rtment of Health and M	-	2000	28408
4	Physici /Medio Examir	al	Registrar Amend#25_Per MF.PCC 8—16—05 cr  1. Decedent's Name (First, Middle, Last)  Marie Annette Liles  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month	Day Year , 2005 4c. County of Death	3. Time of Death 6:00 P M
	Funeral Director		5. Social Security Number  5. Social Security Number  6. Sex  1 M 2 F  7. Age (In yrs. last birthday)  6. Trs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo October	9. Birthpla	ace (State or Foreign ry) Carthage
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, Ite Modical Examiner is ust be notified at Once.	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Married 3 Midowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12th  17. Father's Name (First, Middle, Last)  Joseph Elijah Hampton  19a. Informant's Name/Relationship (Type, Print)  Angela Nelson / Daughter  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee, 430	enham  10f. Zip Code 20623  Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto III)  19 Yes 22 No Specify:  18 Post of work dorne during most of working to NoT use retired)  29 Address (Street and Number or Rura OO Nast Dr. Chelte Sition (Name of Latory or other place)  10 Name and Address of FacilityMars OO Suitland Rd.	Specify: Specify: B  ion  Pvt.  18. Mother's Name (First, Middle, Maiden Sumame)  Julia Ann McLaughlin  Ind Number or Rural Route Number, City or Town, State  r. Cheltenham, MD 20623  Date 20c. Location - City or Security (Clinton)  8-12-05 Clinton,  16 of Facility Marshall's Funeral H  17 nd Rd. Suitland MD 2074		
3760,	/Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Caramy yrange of the conditions of the condit	pine Fracture  Iteart tail  MANY  Causer of Bi	CC-1		Approximate Interval Between Onset and Death
Records, P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	sted by Physician/Med		Ectopic pregnancy Other (specify)  Inderlying cause given in Part I.	1 Tes	cco use contribute to the	Day Year e cause of death? ably 4 □Unknown
Division of Vital Rec	Jing Physician: A. After this certifications of the director,	Certification; To Be Completed	25. Was case referred to medical examiner?  1 X Yes  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  28. Date of Injury (Month, Day Year)  7 22 C 5 6 C  28. Place of Injury - At home, farm, stree building, etc. (Specify)	28c. Injury at Work? M 1 ☐ Yes 2 ☑ No	me 5 Residence 28d. Describe how	prior to condeath?  No 1 Yes  De 6 Other (Specify injury occurred  Schooler in Manager i	leta Access put on Brike
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier  (Check only one)  29b. Signature and title of certifier  29b. Signature and diress of person who completed cause of death (Item 23a) (Type, F	restigation, in my opinion, death occurred at the time, date and place, restigation, in my opinion, death occurred.  29c. License number	and due to the caused at the time, date	se(s) and manner as sta and place, and due to Date signed (Month, D	Day, Year)
	Sta Regist	ate rar	Telton Anderson MO 9400 Li.  31. Date filed (Month, Day, Year)  AUG 1 6 2005	vinestra Rd # 3.	50	u 154m en 20749	Ĉ

State of Maryland / Department of Health and Mental Hygien 2005 28409 For Stata Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death <sup>Day</sup> 2005 AUG. 19, **Physician** 1328 GEORGE HILL LEWIS III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EASTON TALBOT MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC 6 1948 9. Birthplace (State or Foreign Country)

KY 5 Social Security Number **Funeral** Months Min. 1<del>∏</del>M 2□F Days Hours Yrs. 56 Director 137-40-9059 Usual Residence of Decedent 10c. City Town or Location 10d. Inside City Limits 10a State 10b County itam 27 is markad other than "natural", or Itams 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6870 TRAVELERS REST CIRCLE 21601 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1XYes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 Is markad other than Elementary/Secondary (0-12) College (1-4or 5+) MANAGEMENT ANALYST U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be AYLETT OLIVER GEORGE H. LEWIS JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6870 TRAVELERS REST CIRCLE, EASTON, MD 21601 AYLETT O. LEWIS/MOTHER 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ Department of Important: If any injury or once. CHESAPEAKE CREMATION CTR 8/22/2005 STEVENSVILLE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee WELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 200S. HARRISON STREET EASTON, MD. 21601 Joseph 71. OSTAJUSKI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical d. use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause ol death? þ PANCREATITIS, HEPATIC DISEASE, HYPERTENSION 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 X No Hospital or Attending Physician: Be 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 🗌 No ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Diractor: filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Qertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number he and address of person who completed cause of death (Item 23a) (Type, Print) D0044282 **AUGUST 20, 2005** COTIVA CLATTE KOPROWSKI, M.D. 4410 BACHELORS PT. RD. OXFORD, MD. 21654 31. Date filed (Month, Day, Year) AUG 2 2 2005 Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2005 28410 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 5:50 PM DEMAS LATHAM 2005 /Medical August 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury Wicomico Nursing Home Wicomico 8. Date of Birth (Month, Day, Year) 06-06-1922 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Months Days Hours KANSAS, ALABAMA 83 Director 417-36-8213 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or ftems 23a or 28a-f show other traumatic event, the Nedical Examinar must be notified at 1 X Yes 2 No Director WICOMICO SALISBURY the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5979 STONEHEDGE DRIVE 21801 Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊕Yes 2 □ No 1940-If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No by Specify: Specify: WHITE 1946 3 ☑ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 STEAMFITTER PLUMBING INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ROBERT LEE LATHAM NORA RODEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a DIANA LATHAM-DAUGHTER-IN-LAW 5979 STONEHEDGE DRIVE, SALISBURY, MARYLAND 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) injury or permit. Page Department of Important: If any injury or CREMATORY OF DELMARVA 08-13-2005 DELMAR, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 44 23a. Paul. Enter the disease, or complications that shock, or heart failure. List only one cause Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) AILURE 10 **Physician** /Medical Due to (or as a consequence of) **Examiner** EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 □ No the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pg 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No HYPERTENSION 24a. Was an has autopsy LENA certificate CHRONIC 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home P 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only ona) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number -0060515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elder Registrar AUG 1 5 2005

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrar 28411 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Allegith 11, Day 005 Year 8:35 p Charles Ferdinand Lincoln, Sr. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center LaPlata, MD Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Jan. 9, 19 5. Social Security Number 6. Sex 1 Ø M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Director 579-26-7891 80 Yre Washington DC Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, If the Maxical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2801 Moran Drive 20601 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? MXYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Budget Analyst US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Lincoln Mary Louisa Mohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 Moran Drive, Waldorf, MD 20601 <u>Joan P. Lincoln - Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans'Cem 8-17-05 Cheltenham, MD 21. Signature of James, Service Licensee 22. Name and Address of Facility M01391 P. 0. box 156 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one care on each line. Waldorf, MD 20604-0156 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician KDBND. resulting in death) /Medical ue lo r as a consequence of) Examiner Sequentially list conditions, if any k-bard transport of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate ! rmed? 22 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. injury at Work? Certification: ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeref [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-20629 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George H. Wathen MD 11345 Pembrooke Sq., Ste. 103, Waldorf, MD 20603 B511 31. Date filed (Month, Day, Year) istrar's Signature 32. R State AUG 1 6 2005 Registrar

<u>-</u>		1 - For State Registrar	tate of Maryland / I	Depa <i>Cer</i>	ertment of H	lealth and M	lental Hygie	ene 2005	5 28412
Physicia /Medic Examin	al.	Decedent's Name (First, Middle, Last)      Helen Frances     Aa. Facility Name (If not institution, give stree  Dorchester General	et and number)		4b. City, Town, or Cambri	Location of Death	2. Date of Death Month August	Day Year 15, 2005 4c. County of Death Dorche	
Funeral Director		5. Social Security Number 6. Sex 220-12-1783  Usual Residence of Decedent	2 7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept. 29	9. Birth Cor , 1925 Man	nplace (State or Foreign untry) Cyland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be mutified at once.	Funeral Director	Maryland Dorchest 10e. Street and Number 407 Robbins Street	10c. City, Tow		embridge 10f. Zip Code 216	13	10g	. Citizen of What Cor	-
hours after death	by	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?  1	1		ispanic Origin? (Spen, Mexican, Puerto		14. Race - Amer Black, White	ican Indian, a, etc. nite
filed within 72 Hygiene. other than "ne ont, Inc Madic	e Completed	(Specify only highest grade co	Ompleted)  College (1-4or 5+)	(Give l	ab Picker	during most of worki	ng First, Middle, Mai	Shellfis	·
2 should be and Mental is marked o eumatic eve	To Be	Fulton Guy Lewis 19a. Informant's Name/Relationship (Type,				Grac	ie Darli A Route Number, C	n Lewis ity or Town, State, Z	
Pages 1 and 3 ent of Health nt: If item 27 y or other tre		Helen M. Hubbard/Da  20a. Method of Disposition  1	20b. Place o	of Dispos	sition (Name of patory or other place	9)	Pate 200	, MD 21613 c.Location - City or T ambridge,	Town, State
permit. I Departm Importer any inju		21. Signature of uneral Service Licensed	muell	C1 30	Name and Address Irran-Bro 08 High S	omwell Fur L., Cambr	neral Hom idge, MD	e, P.A. 21613	•
/Medical Examiner	Examiner	23a. Part1. Emer the disease, or complicate shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or as a consequence	of):	er the mode of dying	g, such as cardiac c	r respiratory arrest.	Ġ	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	resulting in death) Last  c  d  IF FEMALE: 23h Was decedent pregnant 23c.	Due to (or as a consequence					23d. Date of deliv	very
res that the deat signed by the attu be detached for	Physician/Me	1 Yes No	4□ Pregnant at time of death 9□ Unknown	5 🗆	Ectopic pregnancy Other (specify)			Month	Day Year
w requires the been signer should be d	þ	Part II. Other significant conditions contrib	ting to death but not resulting in	n the un	derlying cause give	en in Part I.	1 ☐ Yes	co use contribute to	
	e Completed	VIA 9 LTS ME//I	775				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
ng Phys (fer this uneral di	ToB	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \) No	Ba. Date of Injury 28b.	utpatient Time of Injury	28c. Injury Work	4 Inursing Hor		e 6  ☐ Other (Speci njury occurred	rfy)
To the Hospitel or Attending F within 24 hours after death. To the Funeral Director; After completely filled in by the funeral	al Certification;	4 Homicide  29a. Certifier Certifying Physicia	Be. Place of Injury - At home, fa building, etc. (Specify)  an: To the best of my knowledge	e, death	occurred at the tim	e, date and place, a	City or Town, S	e(s) and manner as	stated.
To the Ho within 24 To the Fu completely	Medical	(Check only one)  29b. Signatore and title of certifier  Cruce on	On the basis of examination an and manner stated.	id/or inv	29c. License			and place, and due to	
		Eugene New	eted cause of death (Item 23a)	(Type, F	By	nst	Cambric	10 MO	21613
Sta Registra		31. Date filed (Month, Da AUG) 1 7 2	005. Registrar's Signature	de	South			/	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2005

2	Ω	4	1	-
4	O	4		

		1 - For State Registrar	State of Marylar	C	ertificate of	Death		Reg. No		2841
Physic	ian	Decedent's Name (First, Middle,  NORTH NUMBER	•				2. Date of Month	Da		3. Time of Death
/Medi		NORMA NINA MOU							, 2005	10:30 p
Exami	ner	4a. Facility Name (If not institution,			4b. City, Town,	or Location of Dea	ith		. County of Death	
		Doctor's Commu		for and to breath and	Lanhai				Prince G	
Funeral Director		5. Social Security Number  138-03-7919  Usual Residence of Decedent	i. Sex 7. Age (In yrs. 1	Yrs	Months Days			Day, Year)	918 Nev	place (State or Foreig untry) Jersey
death with the Maryland ms 23e or 28e-f show rmust be notified at	_	10a. State 10b. County	10c. C	ity, Town or	Location					10d. Inside City Limit
the Ma 28e-f	Director	Maryland Prince  10e. Street and Number	George's Gr	eenbe	1t 10f. Zip Code		-	100 Cit	tizen of What Cou	1 Ž Yes 2 ☐ No
th with 23e or	al Di	6 Q Hillside	Road		20770				S.A.	muy r
dea	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 1	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (	Specify Yes or I		14. Race - Amer	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Items 23e or 28e-f show any injury or other traumatic svant, the Madical Examinar must be notified at once.	by	1 ☐ Never Married 2 ☐ Marrie 3 🏋 Widowed 4 ☐ Divorced			1 ☐ Yes 2 No		no moan, etc.)		Black, White	hite
in 72 ho n "natu ledical	Completed	15. Decedent's (Specify only highest	grade completed)	16a. De (G.	cedent's Usual Occu ve kind of work done b. DO NOT use retire	pation during most of wo	orking	16b. K	ind of Business/le	ndustry
od within giene. ar than ",	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	,		Own	n Home	
e filed I Hyg otha	a)	17. Father's Name (First, Middle, La	est)			18. Mother's Na	ıme (First, Midd			
uld bu Aenta rrked	To B	William I. Fis	cher			Mattie	st. Cl	lair		
shol		19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Stree				or Town, State, Zi	p Code)
and 2 alth a		Terry A. Mousle	ey – Daughter	6 Q	Hillside	e Road, (	Greenbel	t, Ma	arvland	20770
of He of He itam		20a. Method of Disposition		Place of Dis	position (Name of rematory or other pla		Date		ocation - City or T	
Page nent c		1 🔀 Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spe	IXIHemoval from State	-	Memorial Pa	· 1	8/2005	Egg	Harbor	Twp., NJ
mit. partin porta porta / inju		21. Signature of Funeral Service Lie			22. Name and Addre	1 -				
Departing Department of the policy of the po		Claudette	- Moch Lann							yland 207
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the dea							Approximate Interval Between
Physician		Immediate Cause (Final		C T C	<b>*</b>					Onset and Death
/Medical		disease or condition resulting in death)	a. Pneumonia o  Due to (or as a consec		Lung					8/12/200
Examiner			Chronic Obs		ive Lung I	)iseas <b>e</b>				Years
	ē	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quanca of):						
id ansii	Examine	Cause (Disease or injury that initiated events	c.							
an ar rial-t		resulting in death) Last	Due to (or as a consec	quence of):						
Attanding Physician: The law requires that the death certificate be executed rideath.  actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Medical		d							
ng ph ng ph	Jed	IF FEMALE:					m.	-		
eath cer attendir for use	an/	23b. Was decedent pregnant	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta		B Ectopic pregnanc	v		1	23d. Date of deliv	*
ed fo	Physiclan/I	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o		Other (specify)	,			Month	Day Year
res that the de signed by the a be detached f	h	9 🗆 Unknown								
gned gned	by	Part II. Other significant condition		sulting in the	underlying cause gi	ven in Part I.	23e. Dio	i tobacco u	ise contribute to t	he cause of death?
w require been sig should b		Heart Failure;	Renal Failure				1 🔀	Yes 2	□ No 3 □ Prol	bably 4 □Unknow
e law r has be je 2 sh	Completed						24a. Wa	is an opsy	24b. Were auto	opsy findings available mpletion of cause of
The ste h	E O						per 1 ☐ Yes	formed?	death?	2 No
y <b>sician:</b> The is certificate ha director, page	Be C	25. Was case referred to medical				26. Place of De			1	20110
Physic this ce al direc	ToE	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 X Inpatient 2	ER/Outpat	ent 3 DOA Ott	ner: 4 🗆 Nursing I	Home 5 ☐ Re	sidence (	6 □Other (Specia	(v)
ing Ph J. After th funeral	1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inju	ry at	28d. Describe			,,
death. ctor: After y the funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat		ii i jui		Yes 2 No				
after des after des Diracto	Certification:	3 Suicide 6 Could no 4 Homicide determine		ome, farm, fy)	street, factory, office		28f. Location City or T	(Street and	d Number or Rura )	al Route Number,
spite ours naral		29a. Certifier 1 ☑ Certifying	Physician: To the best of my kno	owledge, de	ath occurred at the ti	me date and place	and due to th	e cause/s)	and manner as s	tatad
To the Hos within 24 h To the Fur completely	edical		aminer: On the basis of examina and manner stated.	ation and/or	investigation, in my	opinion, death occ	urred at the time	e, date and	place, and due to	the cause(s)
To tl withii To tl comp	ž	29b. Signature and title of certifier	10	1	29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
		Sen o	1/1/2/1		D13	339		A110	ust 15,	2005
15)		30. Name and address of person wh	o comp eted cause of death (Iter	n 23a) (Typ				1145	, 1)	2005
		T. Chanchien, M				wyn Hair	hte Ma	rular	d 207/0	
Sta	ite	31. Date filed (Month, Day, Year)	#32 Registrar's Signs	ature		MAII HETE	HED ING	гатап	u 20/40	
Registr	rar	AUG 1 8 200	5 Beech &	100	le					
HMH 17 Rev 1/2	001			1						

State of Maryland / Department of Health and Mental Hygien 2005 28414 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** George Henry McLain August 14, 2005 5:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore TOWSOII

If Under 1 Year If Under 24 Hrs. Min. A Date of Birth (Month, Day, Year)

Jan. 19, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) 124M 2□ F 049-14-3843 **Director** 79 1926 New York Usual Residence of Decedent wods 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked othar than "natural", or liems 23a or 28e-f shov traumatic avent, the Medical Exam a crimust be notified at 1XYes 2 □No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 641 Straffan Drive 21093 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ⊠Yes 2 □ No 1943 It Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Hygiene Door Attendant U. S. Senate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If itam 27 is marked ott any injury or other traumatic aven 900.8. 2 should be fi and Mental F William McLain Mozanna Pugh 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 641 Straffan Drive, Timonium, MD Audrey McLain/Wife 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 8/18/05 4 □ Donation 5 □ Other (Specify) Brentwood, MD 21. Signature of Funegal Service License 22. Name and Address of Facility
Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respiratori Physician to a day /Medical Examiner MONH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician s s the burial Box 68760. attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: 3 🗀 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗀 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29d. Date signed (Month, Day, Year) raries St. State 1 6 2005

Registrar

			For Stete Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H	ealth and Death		iene 2005	28415
			Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month		3. Time of Death
	Physicia /Medic	al	Harry	Lee	McGowar	1		August	8, 2005	6:50 p. <sup>™</sup>
	Examin		4a. Facility Name (If not institution, giv Anne Arundel M		enter	4b. City, Town, or Annapo		th	Anne Ar	
	Funeral Director			Sex 7. Ag 1. MM 2□F	e (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) Co	thplace (State or Foreign buntry) cyland
	ryland thow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	8a-f s	cto	Maryland Anne	Arundel	Arnold					1 ☐ Yes 2 No
	th with the 23a or 2	Funeral Director	10e. Street and Number 1141 Baltimore	-Annapol	is Blvd.	10f. Zip Code 21012			og. Citizen of What Co United St	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene, it is a firm 1.2 I marked othar than "natural", or items 23a or 28a-f show item 27 I marked othar than "natural", or items 23a or 28a-f show othar traumatic event, Itia Madical Examinal must be multiled at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? XIXYes 2 1 If Yes, Give	No I	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2🌠 No	ispanic Origin? (5 n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	te, etc.
Maryland 21215-0036	in 72 hou n "natural	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation furing most of wo	orking	16b. Kind of Business	/Industry
212	d with giene. ir than	шо	Elementary/Secondary (0-12) 1 2	College (1-4or 5	0+)	giver			Children	i
nd	be file stal Hy od otha evant,	Be	17. Father's Name (First, Middle, Last					me (First, Middle, M		
<u>  S</u>	hould d Men marke	은	Edward Lewis M.  19a. Informant's Name/Relationship		19h Mailir	an Address (Street		tina Hac	CKney  City or Town, State,	Zin Code)
<u> </u>	nd 2 s aith an 27 la r trau		Clyde B. McGow	• •		•			er, MD 21	
altimore,	of Hea	1	20a. Method of Disposition	Domewal from State	20b. Place of Dispo	sition (Name of matory or other place	e) Amaria	Date t	20c. Location - City or	Town, State
Ĕ	Pages ment of I ant: If it: lury or o		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Metropolita		2005	5	alexandria, V	
Bal	permit. Pages 1 Department of H Important: If ital any Injury or oth		21. Signature of Funeral Service Lice	nsee					. & Cremation is, Maryland	Services, Inc. 1 21401
8760,	Examiner  the purial-transit  the the burial-transit	dicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I may be any 1 may 1	b. Due to (or as c.	a consequence of):  a consequence of):	aphleco	occi)	Sypsis		Inierval Between Onset and Death
.O. Box 6	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Δ.	ruires that n signed b	by	Part II, Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.		pacco use contribute to	o the cause of death?
l Records,	alcian: The law requir certificate has been si irector, page 2 should	Completed						24a. Was ar autops perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of
/ita	yalcian: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		Oah		ath (Check only on	9)	
ot	Phyal r this c ral dir	-: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 🖺 Inpatie		- V-C-	4 🗀 Nursing	+	nce 6 Other (Spenish injury occurred	cify)
on	nding F ith: :: After e funera	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) Injury	Worl	k? Yes 2 □ No		,	
Division of Vital	al or Attanc after death Diractor: d in by the i	Certification;	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Inj	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	of my knowledge, death f examination and/or in ated.	h occurred at the time vestigation, in my op	ne, date and place pinion, death occ	e, and due to the ca urred at the time, da	tuse(s) and manner a ate and place, and du	s stated. a to the cause(s)
•	To tha within 2 To tha complete	Me	29b. Signature and title of certifier	motor	$m_{\mathcal{O}}$	29c. License	8445	29	9d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who	completed cause of d	leath (Item 23a) (Typ).	Prints A	Vt,	Annum	cho, M	0
ľ	Sta Registr	54	31. Date filed (Month, Day, Year)  AUG 1 2		ar's Signature	book		7		

State of Maryland / Department of Health and Mental Hygien 200528416 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 10 2005 9:50 PM Robert Nathaniel Medford AUgust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Wicomico Nursing Home Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**%** M 2□ F Yrs. Director 201-05-6443 Maryland 4/18/1917 Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic svent, the Medical Examinar must be notified at 1X Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Booth St. 21801 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Army 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 73 h and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Sears Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Coursey Medford Lovey Rebecca Medford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Martha M. Marvel/daughter 4108 Harvest Lane, Salisbury, MD 21804 artment of Health ortant: If item 27 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
Wicomico Memorial
Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/15/05 Salisbury, MD injury `4 □Donation 5 ☑Other (Specify)Entombment HOLLOWay Funeral Home Professional Association 23a. Part. Enter the disease, or complications that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death ABRUMIN AL Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Due to (or as a consequence of): attending physician P.O. Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed ZHEIMERS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an Was .... autopsy performed? 2 X No TIBRILLATION 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of e Hospital or Attending P. 24 hours after death. e Funeral Director: After t 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 🕍 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 0060515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD 21804 614 Easternshore Dr Mahesha Thimmarayappa M.D. AUG 1 5 2005 gistrar's Signature State Registrar

				For	State of Maryland	Departme	nt of Health and	Mental Hygi	ene Legible.	. 201.17
				1 - State Registrar		Certifica	ite of Death	Rag	g. No. UU	
		Physic	ian	1. Decedent's Name (First, Middle, Last				2. Date of Death Month	Day Yea	
		/Medi		Olive Elizabeth   4a. Facility Name (If not institution, give		4b. Cit	y, Town, or Location of Deat	August	12, 2005 4c. County of De	
		Examir	ier	CIVSITA MEDICAL CE			PLATA, MARYI		CHARLES	
Lil		Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last	birthday) If Und	er 1 Year If Under 24 Hrs	8. Date of Birth	Year) 9. B	irthplace (State or Foreign Country) Shington DC
Ш		Director	ı	579-07-0409	JM <b>2</b> NJF   87	Yrs.		March 17	, 1918 Wa	shington DC
Un		yland sow		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
Æ		e Mar ta-fsh Liffed	ctor	Maryland Charles	Wa	ldorf				1 ☐ Yes 2 ☐ No
1		death with the Maryland ms 23a or 28a-f show r must be notified at	Completed by Funeral Director	10e. Street and Number	dustria Amt 10		Cip Code	10	g. Citizen of What (	Country?
77		eath y	eral	2009 St. Thomas			20602	Specify Yes or No-	US 14 Bace - An	nencan Indian,
$\overline{\bigcirc}$	9	after d or Iten	Fun	1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give	1	edent of Hispanic Origin? (Specify Cuban, Mexican, Puer	to Rican, etc.)	Black, Wh	ite, etc.
$\sim$	5-0036	urel',	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:		2 X No Specify:		Specify:	White
-	15-	n 72 h "natu edica	lete	15. Decedent's Edu (Specify only highest grad	le completed)	6a. Decedent's Us (Give kind of v life DO NOT	ual Occupation vork done during most of wo use retired)	rking	6b. Kind of Busines	s/Industry
	212	d withi jiene. r than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Bookkee			Electric	Company
1	힏	e filec al Hyg I othe vent.	BeC	17. Father's Name (First, Middle, Last)	'			me (First, Middle, M.		
1	yla	ould b Ment Markec	10	Edward Harrison				ve Grigsb	<del>/</del>	
SE	Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (T)			ss (Street and Number or R		-	
A	<u>ق</u> ر	Healt Healt tem 2		Jimmy McReady - Gr 20a. Method of Disposition	20b. Place	of Disposition /N	ry Tree Lane,		S MID Z 14 0c. Location - City o	
1CREAD	E O	Pages nent of nt: If i		1 Marial 2 □ Cremation 3 □1  1 4 □ Donation 5 □ Other (Specify,	Removal from State Shena	andoah Me	em. Park 8-16	-05 W	inchester	, VA
7	Saltimore, Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or liems 23a or 28a-f show eny injury or other traumatic event. The Medical Examinat must be notified at once.		21. Signature of Funeral Service Licens	M01391	22. Name	and Address of Facility		Box 156	
) -		70 F 9 9		Hantegle			Funeral Home		f, MD 206	
				23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.					Approximate Interval Between Onset and Death
		/Medical		disease or condition resulting in death)	a Due to (or as a consequence		+TORY	FAILL	RE	FEW HOURS
		Examiner		Comments the line was divined	CHRON	ic os	STRUCTIU	2 Palr	TONARY	HANY YEARS
		D #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequent	ce oi).	STRUCTIU	2	SEASE	
	_	xecute and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence		ESE ME	ELL/748		UNKNOWN
	760,	e be e. sician e buria	calE		· ·	PSis				CINKNOWN
		tificate ig phy as the			u					
	Вох 68	ith cer tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		pregnancy		23d. Date of d	•
	P.O. E	he dea the at thed fo	Physiclan/Med	1 ☐ Yes 2 ⊠No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (	specify)		Month	Day Year
		that the	y Ph	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying	cause given in Part I.	23e. Did toba	icco use contribute	to the cause of death?
	rds	quires in sign	ed by	F	BOOMINAL	< P2U	vic MASS	1 ☐ Yes	2 No 3 7	robably 4 Unknown
	900	law re as bee 2 sho	Completed					24a. Was an autopsy		autopsy findings available completion of cause of
	E E	The ate has page	Com					performe	ed? death?	s 2 No
	Vita	icien: certific ector,	Be	25. Was case referred to medical examiner?	Josnital: 1 /			ath (Check only one)		
	of	Phys r this ral dir	1: To	1 Yes 2 No	Hospital: 1 Inpatient 2 □ ER/	Outpatient 3 E	OCA Other: 4 Nursing F	lome 5 Residen 28d. Describe how		ecify)
	ion	nding ath. r: Afte e fune	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	Work? 1 □ Yes 2 □ No		,,	
	Division of Vital Records,	r Atte er deg rector	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, facto	ory, office	28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
	D	urs aft		× 0 111						
		To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowled iner: On the basis of examination and manner stated.	ige, death occurre and/or investigation	d at the time, date and place on, in my opinion, death occu	e, and due to the cau irred at the time, date	se(s) and manner a o and place, and du	as stated. le to the cause(s)
		Fo the	Me	29b. Signature and title of certifier	and manner stated.	2	9c. License number	290	d. Date signed (Mor	oth, Day, Year)
					J. P. Sha	D	-21173		8/13	105
	?	W F		30. Name and address of person who co				<u>i</u>		
	F	200		Sharma, Niran P.,	MD 3460 Old Was	hington	Road Waldorf	, Maryland	20602	
		Sta Registi		AUG 1 6	2005	or Apan				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 05 For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** コヨリデ MANCI 12 2009 20mAs /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Survie PAITO If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 15 9. Birthplace (State or Foreign Country) 1930 Rhode Island If Under 1 Year 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 035-20-9272 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Anne Arundel Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7062 Timberfield Place 21226 US Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ten any injury or other traumatic event, the Medical Examinat 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Francis McHale, Sr. Edna Sleczkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6259 Hard Bargain Circle, Indian Head, MD 20640 Carol Anne McHale - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Arlington National Cem 9-8-05 Arlington, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service License M00053 P. O. Box 156 Huntt Funeral Home Waldorf, MD 20604-0156 ∕∂. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician previoselerotic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy page 2 should be detached for in the past 12 months? Month Dav Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 20 or Attanding Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number DO006654 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - America 21035 TONES, MD 31. Date filed (Month, Day, Year) State AUG 1 6 2005 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 2005 28419 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 18 2005 Dorothy 5:00 A Mae Nelson August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Caroline Home Denton Ruxton's Nursing If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Vrs 93 Maryland 017-26-2774 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other treumatic event. In Medical Examples notified and any significant. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Caroline Denton Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 420 Colonial Drive 21629 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Family House Keeper UNKNOWN 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be 2 Unknown Katie Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred R. Williams / Nephew 23990 E. Cherry Lane, Goldsboro, Maryland 21636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Cheterfield Cem. 08-23-2005 Centreville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bennie Smith Funeral Home -muras 717 W. Division Street, Dover, Delaware 19904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on \_acr \_line. Approximate Interval Between Onset and Death 10411 Immediate Cause (Final zheeme **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Mo
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2000 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 rsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 o 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HNDNEA ALLONGO

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 2 2 2005

gistrar's Signature

			1 - For State Registrar	State of Maryla	nd / Depa	artment of H	lealth and Death		giene 200	5 28420
		•	Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth	3. Time of Death
	Physici /Medic		Brandon D.	Perritt				Augus	t 6, 200	6.4
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Deat	h	4c. County of E	Peath
			1405 Shady Glen				stville			e Georges
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr.	s. last birthday)	Months Days	If Under 24 Hrs Hours Min.	(Month, Day		Birthplace (State or Foreign Country)
	Director		577-21-2073 Usual Residence of Decedent		14 "			Jan.27	, 1991 1	Wash, DC
	yland Jow		10a. State 10b. County	10c. 0	City, Town or Lo	cation				10d. Inside City Limits
	Mar Miled	ctor	Md. P.G.		Forest	ville				1 X Yes 2 □ No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?
	ath w	ral	1405 Shady Glen			2074			United	States
	er de	<b>Funeral Director</b>		2. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
36	within 72 hours after death with the Maryland ene. then *naturef', or Items 23e or 28e-f show f.a M. dical Examilher in ust be mailfied at	by F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	I □ Yes <b>¾</b> □ No	Specify:		Specify:	l o als
21215-0036	2 hou	ted	15. Decedent's Educ	cation		lent's Usual Occupa		4	16b. Kind of Busine	lack ess/Industry
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done o OO NOT use retired	during most of wo	nking		
7	ed wi	ပ္ပ	8		S	tudent			Educa	ation
Ē	be fill d off	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
Maryland	d Mer narke netic	ဥ	Demetrius Macke		10h Mailia	an Address /Street		lla Per	ritt r, City or Town, Stat	in Tie Code)
Ma	d 2 sl th and th and 7 is r		Darnella Perritt	•	1405	Shady (	Glen Dr	ive	127921920	e, zip code)
<u>6</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or Items 23a or 28e-1 show entry or other treumetic event, It a Marical Examiner must be multiled at ODGs.		20a. Method of Disposition		Place of Dispo	stville sition (Name of		Date 20	747 20c. Location - City	or Town, State
ê E	Pages ent of nt: If I		1 ⊠Burial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)		-	Mom Do		12/05	Landover	- 14.4
Baltimore,	mit.		21. Signature of Funeral Service License		22	. Name and Address	ss of Facility H	odaes &	Edwards	F H
m	Depar Depar Impor eny ir		Januce	Edwar	dr39	10 Silv	er Hil	l Rd.,	Suitland	d,Md.20746
			23a. Part1 Enter the disease, or complice shock, or heart failure. List only one	cations that caused the de- e cause on each line.	ath. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
8	Enysician		Immediate Cause (Final disease or condition	Maligy	ant	Brain	Tumor			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
		<u>.</u>	Sequentially list conditions,	. Due to (or as a conse	equence of:					<del></del>
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		, , , , , , , , , , , , , , , , , , , ,					
o,	exection and and rial-tra	Exa	that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):					
8760,	icate be executed physician and s the burial-transit	dical	<b>L</b> d							
မ	ing ph e as t	Med	IF FEMALE:		1977 - 371					
Box	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1☐Live birth 2☐Fe	tal death 3□	Ectopic pregnancy			23d. Date of Month	delivery Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5 ∟	Other (specify)				,
Records, P.O.	The law requires that the death certific sie has been signed by the atlending p page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions conf	tributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
rds	quires than signed ald be del	q p						1 □ Y	es 2⊠No 3⊑	Probably 4 Unknown
Ö	sw require s been sign	ojete						24a. Was a	ın 24b. Were	autopsy findings available
æ	The law	Completed						autop: perfor	med? prior death 2X No 1 1	to completion of cause of 1? ∕es 2⊠ No
ita	sien: artifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only or		
<u></u>	hysic this ce al dire	2	1 ☐ Yes 2 🙀 No		□ER/Outpatien		4 🗆 Nursing F		ence 6 Other (5	Specify)
Division of Vital	ling P	ion;	27. Manner of Death 1  Natural 5  Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	k?	28d. Describe h	ow injury occurred	
8	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm stre		Yes 2 □ No	28f Location (S	treet and Number o	Rural Route Number,
<u>≥</u>	after Direction by	Certification;	4 Homicide determined	building, etc. (Spec	cify)	soi, raciory, omoe		City or Tow		ribidi riodo ribidos,
	To the Hospitel or Attending Physicien: The within 24 bours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kiler: On the basis of examinand manner stated.	nowledge, death	occurred at the time restigation, in my or	ne, date and place pinion, death occu	e, and due to the curred at the time, c	ause(s) and manner late and place, and c	r as stated. due to the cause(s)
	omple	Me	29b. Signature and title of certifier	414	nding	29c. License	e number	2	9d. Date signed (M	onth, Day, Year)
	->-0		) T.W.	SMD.		+ MD	3117	5	08/10	6/2005
0			30. Name and address of person who cor	mpleted cause of death (Ite	em 23a) (Type,	Print)			4	
_				iald, M.D.,	III Mi	chigan 1	Avenue, A	J.W. Wa	Shington	, DC 20010
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 6 2005	2. Registrar's Sign	nature	E)				

State of Maryland / Department of Health and Mental Hygiene 2005 28421 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:12 AM rederic 05e 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomer Burtonsville i 1 If Under 1 Year If Under 24 Hrs. NUSING and elab 6. Sex () 7. Age (In yrs. last birthday) Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 578-40-2466 18 M 2□ F 75 Director 12,1930 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r then "natural", or Items 23a or 28e-f show the Medical Exemples must be redified at 1₺Yes 2 No MDPrince George's Laure1 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 12405 Eastgate Lane United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 函 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 E No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookbinder Bureau of Engraving 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other treumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hazel Rogers Howard William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12405 Eastgate Lane Laurel, MD 20708 Ruth Posey (wife) 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 8/12/2005 Brentwood, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 estros int. Enter the disear, or emplications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed CABE Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2□ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 150932 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VILMA KENILWORTH 6502 #100 31. Date filed (Month, Day, Year) State AUG 1 6 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2005 28422 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:55 PM 2005 Duckett B. Pointer AUGUST /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Manor Healthcare Center Property Rising Sun

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Cecil 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Year) Jan. 14 1 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 90 Yrs. 259-16-9721 Georgia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Maruland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 Maple Heights Lane 21911 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Exterminator Pest Control other permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Pointer Elmer Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Thompson/Daughter 321 Maple Heights Lane, Rising Sun, MD 21911 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 8-16-2005 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State R. T. Foard Funeral Home, P.A. \* 4 ☐ Donation S Other (Specify) Rising Sun, Maryland 21. Signal e of Foural Service Licensee R. T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA - ALZHEIMEN'S TYPE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a O. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CORDNAY AMERY DISTRAGE 1 Yes 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC OBSTRUTTE PLYMONDRY DISTENSE 24a. Was an has page 2 autopsy performed? certificate DIABETES MEDUTAS 9€ No 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes → No this Atter the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation Natural Injury death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 15, 2005 #58419 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1881 TELEGRAPH ROAD, RING SUN MD DONHAM D.D. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		For State Registrar	State of Maryland	/ Department of H Certificate of L		ntal Hygien ک Reg. No	2000 2042	3
Physic /Medi		1. Decedent's Name (First, Middle, Last	1. Purrell	Sr.	2.	Date of Death Month Day	2005 3. Time of Death 5:20 A M	И
Exami		4a Facility Name (If not institution, give	street and number) g and Rehabill	tation Certe	Location of Death	2/17	County of Death Words#	
Funeral Director		221-14-125	7. Age (In yrs. last	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreig	חן
Maryland f show	ō	Usual Residence of Decedent  10a. State  10b. County  WORCE	_	Town or Location  BERLIN			10d. Inside City Limits	
with the Marylan e or 28a-1 show Lbe notified at	Director	10e. Street and Number	. 5	10f. Zip Code	811	10g. Cit	izen of What Country?	
ie, Man y lating 2.12.15.0000 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygene. If the marked other then "natural", or Items 23e or 28e-1 show titem 27 is marked other then "natural", or Items 2.00 or 28e-1 show other traumatic event, the Medical Evertings rust be nutitived at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  12. Yes 2 No ARM If Yes, Give Year or Dates:	13. Was Decedent of Hi		y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.  Specify: BLACK	
ithin 72 hours ne. nen "natural", Medical Eve	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	lurina most of workina	16b. K	ind of Business/Industry	
oe filed within all Hygiene.	Be Cor	17. Father's Name (First, Middle, Last)		TRUCK	18. Mother's Name (F	irst, Middle, Maiden	ONSTRUCTION Sumame)	
a y all a filed within 2 should be filed within and Mental Hygiene. Is marked other then aumatic avent, I'm M	T <sub>o</sub>	19a. Informant's Name/Relationship (7	PURNELL Type, Print)	19b. Mailing Address (Street a	HDA and Number or Rural R	Oute Number, City o	or Town, State, Zip Code)	
00		JAMES R. PURNE  20a. Method of Disposition  1 Burial 2 Cremation 3	COM	ce of Disposition (Name of netery, crematory or other place	Date Date	SERLIN MI 20c. Lo	2   8   1 Docation - City or Town, State	
permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr	1	'4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen:	) ST. P.	AULS CHOACH C	EM 8/20 is of Facility BE	105 BE VALE SM	ALIN MD	-
n goesa		23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the death, one cause on each line.			SAUSBURU espiratory arrest,	Approximate Interval Between	_
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aCerchova	uscular ac	cident		Onset and Death  YEA	
Examiner	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	bDue to (or as a consequer	nce of):				
ficate be executed physician and ts the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequen	nce of):				
artificate bing physice as the b	Medical	IF FEMALE:	d.					
w requires that the death certific been signed by the attending f should be detached for use as	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic pregnancy			23d. Date of delivery  Month Day Year	
requires that sen signed by nould be detailed	by P	Part II. Other significant conditions of Maheles me		ing in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to the cause of death?	n
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funarel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit	ompleted	denesta				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 → No	е
vician: The lavicertificate has	Be C	25. Was case referred to medical examiner?	Hospital:	2/Outrestient 2/1 BOA Othe	26. Place of Death (C	Check only one)		
ng Physical this neral dil	n: To	1 ☐ Yes 2 ☐ No  27. Mannar of Death 1 ☐ Natural 5 ☐ Pending	1 Inpatient 2 EP	8b. Time of 28c. Injury Work	at 280	5 Residence  Describe how inju	6 ☐Other (Specify)  ry occurred	
To the Hospital or Attanding Physician: The lawithin 24 hours after death.  To the Funarel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M 1 🗆 '	Yes 2 □No 28f	Location (Street ar City or Town, State	nd Number or Rural Route Number, s)	
To the Hospital within 24 hours a To the Funarel Completely filled in	75	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the time n and/or investigation, in my o	ne, date and place, and pinion, death occurred	due to the cause(s at the time, date and	) and manner as stated. d place, and due to the cause(s)	
To th within To th compl	Me	(Check only 2   Medical Example)  29b. Signature and title of certifier  Warth 1  30. Name and address of person who of KLLSTIME (RIFF)  31. Date filed (Month, Day, Year)  AUG 1 5 2	Sugar, M	29c. License  0	006795	29d. Da	te signed (Month, Day, Year)	
11,		30. Name and address of person who of KELSTIME CORIF	completed cause of death (Item 2:	3a) (Type, Print) COASTAL 1+	WHUAY, F	ENVICE	ISLAND, DE 1990	44
St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 5 2	2005 32. Palistrar's Signatur	4. Sparle				

Purnell, James M. Sr.

December   Service   Ser				1 - For State Registrar	State of Ma	ryland / [	Departr <i>Certifi</i>	ment of F icate of I	lealth and M Death		giene Reg. No.	2005	284	21
## County of Death   As Designed   As Enable   As Designed   As Enable   As Designed   As Enable   As Designed   A				1. Decedent's Name (First, Middle, Las	0 1	ann					Day		المسرد	th ∱M
Discourted by the control of the con		Examin		Coastal Hos	pice at	He L	thday) If	Under 1 Year	Misbu If Under 24 Hrs.	8. Date of Bir	h	Jicom 9. Birtho	lace (State or Fo	preign
Top   Dec				470-92-8033	ДM 2□F	67	Yrs.	onths Days	Hours Min.	10-15-	1937			
Benneralary/Secondary (0-12)   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   The Company   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   College (1-fut 5-1)		anyland show	J.	10a. State 10b. County				on				1	•	
Benneralary/Secondary (0-12)   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   The Company   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   College (1-fut 5-1)		the M	recto		ICO	SALISB		Of. Zip Code			10g, Citize	en of What Coun		
Benneralary/Secondary (0-12)   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   The Company   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   College (1-fut 5-1)		23a or	al Di	5570 CHANNEL DRIVI	Ξ				21801					
Benneralary/Secondary (0-12)   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   The Company   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   College (1-fut 5-1)	36	rs after dea i, or Items	y Funer	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give					ecify Yes or No Rican, etc.)		Black, White,	etc.	
Benneralary/Secondary (0-12)   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   The Company   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   STANDARD   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   Standard   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   COMPANY   College (1-fut 5-1)   ENGINEER   ELECTRIC COMPANY   College (1-fut 5-1)	8	2 hous	ted t	15. Decedent's Ed	ucation	16a.	Decedent'	s Usual Occup	ation	ina	16b. Kind			
Provision // / / / / / / / / / / / / / / / / /	121	vithin 7 ne. han "r	mple		Cotlege (1-4or 5-	-)	life. DO N	VOT use retired	during most of work	ing .		ICEDTO C	03.673.4.3777	
Provision // / / / / / / / / / / / / / / / / /		filed v Hygie other t		17. Father's Name (First, Middle, Last)	D+		EN	GINEER	18. Mother's Name	e (First, Middle			OMPANY	
Provision // / / / / / / / / / / / / / / / / /	/lan	Mental Mental arked artic ev	To B	KARL PORTMANN					GERTRUDE	BECK				
Provision // / / / / / / / / / / / / / / / / /	Man	12 sho h and l 7 Is ma reuma	i y		,, ,	1					•			
Provision // / / / / / / / / / / / / / / / / /		Healti Healti tem 2			SPOUSE	20b. Place of	Disposition	n (Name of						
Provision // / / / / / / / / / / / / / / / / /	m m	Pages nent of int: If i				1		-	-	4-2005	DELMA	R, MARY	LAND	
Physician (Account (Final allure, List only one cause) feach line.    Physician (Account (Final allure, List only one cause) feach line.	Balt	permit. Departr Importe eny inji		21. Signature of Funeral Service Licent	21.									
Physician (Medical Examiner    Physician (Medical Examiner)				shock, or heart failure. List only of	olications that saused tone cause in each tine	Э.	*		-				Interval Between	n th
The part of the pa				disease or condition	a. NATU.	RAL	KILL	BR	CRLLL	IMPH	on	4-	6 word	14
The part of the pa					BiLA	4 TRK	24	- F	NZUN	CNIP	1		2 West	les
Second   S		sit sit	iner	cause. Enter Underlying	Due to (or as a									
Second   S	_,	execute n and al-tran	Exam	that initiated events	c Due to (or as a	consequence	of):							
The past 12 months?  The past	3760	ate be hysicia the bur	ical	(	d									
The state of the s	_		/Med		23c. If ves. outcome of	of pregnancy					23	ld. Date of delive	in/	
The state of the s		t the death by the atter ached for u	hysiciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetat death					20			
Performacy   Control of the contro		quires tha en signed l	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	n the under	lying cause giv	en in Part I.			,		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AHMAM WAR IS NO 26266  ARROWWOOD CT. SA LISBURY and 2	Reco	9 4 9	omplet							auto perfo	psy ormed?	prior to cor death?	noletion of cause	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AHMAM WAR IS NO 26266  ARROWWOOD CT. SA LISBURY and 2	Vital		Be	examiner?	Hospital:			Oth			one)			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AHMAM WAR IS NO 26266  ARROWWOOD CT. SA LISBURY and 2	of	Phys r this ral dir	H-	1 192 5 VAO	28a. Date of Injun	28b. 1	Time of	DOA	4 🗀 ivursing no				HOSPIC	R
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AHMAM WAR IS NO 26266  ARROWWOOD CT. SA LISBURY and 2	ion	ath. or: Afte	atlor	2 Accident investigation		Year) t								
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  ATUAM WAR IS NO 26 266  ARROWWOOD CT. SA LISBURY and 2	Divis	or Atter de after de l'Directe	ertific		200. Place of triju	ry - At home, fa . <i>(Specify)</i>	ırm, street,	factory, office		28f. Location ( City or To	Street and wn, State)	Number or Rura	l Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AHUAM WAR IS NO 26266 ARROWWOOD CT. SALISBURY in 2		ne Hospitu 124 hours ne Funera letely fille		(Check only Z Medical Exam	iner: On the basis of	examination an	e, death occ d/or investi	curred at the tir gation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) as date and p	nd manner as st place, and due to	ated. the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LHULAM WAR IS NO 26266 ARROWWOOD CT. SALISBURY and 3		within To the comp	Ĭ	29b. Signature and title of certifier							29d. Date	signed (Month,	Day, Year)	
CHULAM WARIS NO 26266 ARROWWOOD CT. SALISBURY up ?	,	B		- Str		2 Com	Cr		5 24/0	,	2/	112/05		
		100							ROWWO	00 C	T. St	4 LISRY	Thy ins	2180.
				31. Date filed (Month, Day, Year)										

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005

Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) August 10, 2005 Pear **Physician** 1658 р м Jeanette Judy Reddick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Prince Georges' Cheverly Community Hospital If Under 1 Year If Under 24 Hrs. A Date of Birth (Months Days Hours Min. 03/14/1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2√F 62 Washington, DC Director 577-66-4116 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23s or 28s-f show other traumetic event, the Mcdical Examinar must be notified at M Yes 2 No Director MD P.G. Capital Heights 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20743 U.S.A. 1101 Clovis Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ng most of working s 1 and 2 should be filed within a if Health and Mental Hyglene. Item 27 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Private Housekeeper 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Lester Francis Reddick, Sr. Jennie Eva Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3720 First Street, S.E.; Washington, DC 20032 Asia V. Reddick - Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Cem 8/19/2005 Landover, MD 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Foreral Service Licenses P.O.Box 416; Suitland, Maryland 20752 23a. Part1. Enter he disease, or complica shock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to far as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Indexplying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed use as the burial-transit resulting in death) Last the attending physician Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Typs 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 20 Other. 1 Tyes No Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral c Date of Injury (Month, Day Year) 27. Manger of D ath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a 29a. Certifier Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address

eurgo's ACEPITE legistrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

AMANDA

State of Maryland / Department of Health and Mental Hygiene

					Certificate	of Death		Reg. No.	105	28427
Dhusia	ian	1. Decedent's Name (First, Middle, Les	t)				2. Date of		Year	3. Time of Death
Physic /Med		Donald Luther Rho	ads II				Augus	1 15,26	05	06:45 AM
Exam		4a Facility Name (If not institution, give					, or Locetion of De		y of Death	
		2651 Old Telegrax					eake Cit		ecil	
Funeral Director		5. Social Security Number  182-22-6315  Usual Residence of Decedent	x 7. Age (In y		hday) If Under 1 Months I		Min. (Month,	Birth Day, Year) 26,1930		place (State or Foreign ntry) INSYLVANÍA
and w		10a. State 10b. County	10c.	City, Town	or Location				1	10d. Inside City Limits
Maryl	5	Maryland Ceci	: p	Cha	sapeake C	<i>i+.,</i>				1 ☐ Yes 2 💢 No
158 15e	Director	10e. Street end Number		_ cne	10f. Zip Co			10g. Citizen of	What Cour	ntrv?
Sa of		2651 Old Telegrax	h Road			21915		us	A	
death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever i	n U,S.	13. Was Deceden	t of Hispanic Origin' Cuban, Mexican, P	? (Specify Yes or		ce - Americ	
be filed within 72 hours efter death with the Maryland tiel Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify 1 ☐ Yas 2 ☐		uerto Rican, etc.)	Specil	ick, White, fy: Wh	etc. ite
72 hours natural;	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a.	Decedent's Usual C	Occupation	working	16b. Kind of B		
Fig. 1	ple	Elementary/Secondary (0-12)	College (1-4or 5+)			done during most of retired)				
ar the	Son		5	Dir	ector of	Internat	ional Ma	iketing p	harmo	aceutical
of the time of time of the time of time of the time of	Be (	17. Father's Name (First, Middle, Last)					Name (First, Midd	lle, Maiden Sumar	ne)	
Meni Meni	2	Donald L. Rhoads				Ann	Klein			
and and series		19a. Informant's Name/Relationship (T	ype, Print)	19b.	Mailing Address (S	Street and Number o	r Rurel Route Nun	ber, City or Town	, State, Zip	Code)
and ealth n 27		Sandra Collins/Da		26	551 Old T	elegraph	Road, Ch	esapeake	City	, MD 21915
of H fiten		20a. Method of Disposition 1	1	b. Place of	Disposition (Name r, crematory or other	of	Date	20c. Location	- City or To	wn, State
Pag nent ant: I		4 □ Donation 5 □ Other (Specify)		t. Au	oustine (	Cemeteru	8-17-20	05 Cheso	meab.	city, MD
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "nu any injury or other traumetic event, the Medion 26.		21. Signatura of uneral Service Licens	m(2)		R. T. F	Address of Facility oard Fune rge St.,	ral Home	. P.A.		-
		23a. Par . Enter the disease, or comp shock, or heart failure. List only o	lications that caused the d	eath. Do n	ot enter the mode of	f dying, such as car	diac or respiratory	arrest,	MU Z	Approximate
Physician		snack, or heart failure. List only o	ne cause on each line.						i	Interval Between Onset and Death
/Medical		Immediate Cause (Final disease or condition	( and in		460				1	
Examiner		resulting in death)	a. Cardiom  Due 6	o (or as a o	onsequence of):					
	ē		ASUV		ondequentes siy.				1	15
outed nd rensi	Examiner	Sequentially list conditions	•.		onsequence of):					15years entuewn
an er	Ĕ	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	e diabet			· · ·	1 7		İ	*
ysicia ysicia	edicai	Cause (Disease or injury that initiated events resulting in death) Last	Due to	(orasaco	onsequence of):	45,190	t. Z			INNHEWS
eath certificate be executed attending physician end for use as the buriel-trensit	Jed	resulting in death) Last		(	,				-	
e law requires thet the death cer hes been signed by the attendin ge 2 should be deteched for use	M/M		d							
The law requires that the death ate hes been signed by the atter page 2 should be deteched for	Physician	Part II. Other significant conditions con	ntributing to death but not	resulting in	the underlying caus	se given in Part I.	23b. Di	d tobacco use co	ntribute to	the cause of death?
t the by th	hys				and an admy mg was	given are dit i				bably 4 Unknown
s the	by P						_	4,100 22,110	0	
quire n sig uld b	교						24a. Wa	s an autopsy	24b. We	ere autopsy findings
w rec	Completed		11789				per	formed?	cor	ailable prior to mpletion of cause death?
he la e hes age 2	Ĕ						10	Yes 2 No		Yes 218 No
		25. Was case referred to medical				OC Plans of			'	Tres Zua No
Attending Physician: The last death.  st death.  ector: After this certificate hese by the funerel director, page 2	o Be	examiner?	dospital: 1 ☐ Inpatient 2	☐ ER/Out	patient 3 DOA	Othor	Death (Check only		/0	
Phy reld	1: To	27. Manner of Death	28a. Date of Injury	28b. Ti		Injury at Work?	1	sidence 6 Lioth how injury occur		<u>"</u>
ding th.	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year		ury M	Work? 1 ☐ Yes 2 ☐ No		, ,		
deal deal ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farr	n. street, factory, of		28f. Location	(Street and Numb	er or Rura	l Route Number.
or lefter Olre	err	4 Homicide	building, etc. (Spe	cify)	,,, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or T	own, State)		
To the Hospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funerel	C	29a. Certifier 15 Certifying Phys	sician: To the best of my k	nowledge	death occurred at ti	he time, date and ni	ace, and due to th	e ceuse(s) and ma	anner as st	ated.
24 h	edical		ner: On the basis of exam and manner stated.							
vithin o the	≊	29b. Signature and title of certifier				cense number		29d. Date signe	d (Month, I	Day, Yeer)
- × - 0		wally	hum M.	0	00	103577	9	Augus	1 15	2005
10		30. Name and address of person who co	ompleted cause of death (I	tern 23a) (T	ype, Print)	hemiah	Ave, Ce	illon	md	2/9/3
	_	31. Date filed (Month, Day, Year)	32 Registrar's Sir	nature			, -			9070
Sta Registi		AUG 1 6 2005	32. Registrar's Sig	do	de					
				7						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Timothy J. Sarvey 05-5438 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

<b>,</b>		1	For State Registrar	State of Maryland	/ Depa	rtment	of Health and N of Death	Mental Hygi	iene 2005	28428
Phy	sicia	_	Decedent's Name (First, Middle, Last)     Timothy James	Sarvey	-			2. Date of Death	1, Day 2005 Yeer	3. Time of Death 5:53 P M
	edica imine		4a. Facility Name (If not institution, give str. 313 West End Avenue			46. City, To	own, or Location of Death	1	4c. County of Dea Dorcheste	
Fune Direc			5. Social Security Number 6. Sex 1 158 h	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Months I	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Jan. 6,	9. Bi 1956 Ma	thplace (State or Foreign ountry) ryland
aryland			Usual Residence of Decedent  10a. State 10b. County  MD Dorchest		Town or Lo		Cambridge			10d. Inside City Limits 1   Yes 2  No
with the M a or 28a-f		5	MD Dorchest  10e. Street and Number  313 West End Ave.			10f. Zip C		10	0g. Citizen of What C	ountry?
be filed within 72 hours after death with the Maryland trai Hygiene.		by Funeral		Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Deceder f Yes, specifi l □ Yes 20	nt of Hispanic Origin? (S y Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
within 72 hours affiene.	I've Marallean	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ition	(Give life. [	dent's Usual kind of work DO NOT use disabl	done during most of wor retired)	king	did not w	
2 should be filed want and Mental Hygie		To Be C	17. Father's Name (First, Middle, Last) Paul Gustav Sarve	èУ			18. Mother's Nam	ne (First, Middle, A Ddetta Ler		
and 2 sho ealth and m 27 is m			19a. Informant's Name/Relationship (Type Rebecca Whitelock	sister			Street and Number or Ru coit Drive,			
Pages 1 and the matter of Herman	y or our		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Rei  4 □ Donation 5 □ Other (Specify)	moval from State	netery, cren	sition (Name natory or oth Vetera	er place)	16/05	20c. Location - City o Hurlock,	
parmit. Pages 1 and 2 Department of Health Important: If Item 27 is	DDC.	İ	21. Signature of Funeral Service Licensee		22	. Name and		homas Fu	neral Home	P.A.
Division			23a. Part Enter the disease, or complication shoot, or heart failure. List only one Immediate Cause (Final		Do not ente	er the mode	of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physic /Medi Exami	cal			Due to (or as a conseque	ence of):	LUISU	Se complicated	MA PAR	The nace	
petr	III III	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseque	ence of):					
te be executed ysician and	3	cal	resulting in death) Last	Due to (or as a conseque	ence of):					
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funsrel Director: After this certificate has been signed by the attending physician and	Ched for use as it	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Ectopic pre			23d. Date of d Month	elivery Day Year
us, r juires that n signed b	ald be deta	2	Part II. Other significant conditions conti	ributing to death but not result	ting in the u	nderlying car	use given in Part I.			to the cause of death?  Probably 4 Unknown
The law requir	. page 2 snot	Completed						24a. Was a autops perform	sy prior to med? death?	
ysicien ysicien	director	To Be	25. Was case referred to medical examiner?  1↓ Yes 2 □ No	spital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3 DOA	Other		ence 6X1Other (Sp	ecifyat scene
nding Phy ath. rr: After thi	ie tunera		27. Manner of Death 1 □ Natural 5 □ Pending 2 Stacklent investigation	28a. Date of Injury (Month, Day Year) FOUND8-11-05	28b. Time of Injury 20110	Рм <sup>28</sup>	c. Injury at Work? 1 □ Yes 2 XNo	_	ow injury occurred D	T. L.
DIVIS al or Atte s after dez	ad in by tr	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	reet, factory,	office	28f. Location (St City or Town Canbon dg		Rural Route Number, 18t End. And, 16ster Co,
s Hospit 124 hour e Funsre	letely tille	edicai (		cian: To the best of my know er: On the basis of examination and manner stated.						
To th within To th	сош	Me	29b. Signature and title in certifier	In M			C.M.E.		9d. Date signed (Mor August 12,	
			30. Name and address of person who con	npleted e of death (Item			Street, Bal	timore,	Maryland	21201
Re	Sta		31. Date filed (Month, Day, Year)	32. Registrads Signatu	ure	do	de			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death 28429 1 - For State Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0800 AM 12 05 Oneita Webster Smith /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Dorchester General Hospital Cambridge 8. Date of Birth (Month, Day, Year) 1, 1922 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 250 F Months Maryland Director 220-16-9883 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov other traumatic event, the Medical Examiner must be notified at Cambridge 1 Yes 2 No MD Dorchester Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21613 USA or Itams 23a 105 Hiawatha Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Midowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) receptionist newspaper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Is marked ot Be Lena Ewell John Webster ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health and Importent: If Item 27 Is rr any Injury or other traum once. Norman M. Smith Jr. 5424 Cannon Road, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Dorchester Memorial Park 8/16/05 Cambridge, MD 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Funeral Service Licensee 21. Signature 700 Locust St., Cambridge, MD 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal End Physician /Medical Due to (or as a consequence of): Para protecuis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as consequence of) Examiner burial-transit certificate be executed Se 1 cenus that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 lan/Medical ading phys use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter fo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) Physic 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 200 | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8-12-05 D47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMARIDGE THANKY 300 AURORA NOMAN 2005 32. Receirar's Signature 31. Date filed (Month, Day, Year) State Registrar

Sm, TH,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 28430 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death

**Physician** /Medica Examine

1 - For State Registrar

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than \*neturel', or Items 23a or 28e-1 show any injury or other treumatic event, Ire Medical Examinational be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician** /Medical Examiner Medical Certification; To Be Completed by Physician/Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

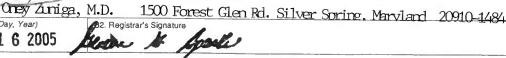
To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ı		hesteri	TETA		Swann				August 1	12, 200	05 Year	3:35 A. M
į	4a. Facility Name (If not in Holy Cross H		e street and nu	mber)		4b. City, Town, o	r Location o	f Death		4c. Co	ounty of Death	1
	5. Social Security Numbe 216-40-9411	1	ex M 2□F	7. Age (In yr	s. <i>last birthday)</i> 62 Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birt (Mooth, Da	h		place (State or Foreign
ŀ	Usual Residence of Dece 10a, State 10b.			10.0								
		county ince Geo	orge's	10c. C	City, Town or Lo		restvill	le				10d. Inside City Limits  12€Yes 2 □ No
	10e. Street and Number 3205 Wal	ters La	ne			10f. Zîp Code	20747				n of What Cou	untry?
	11. Marital Status  Never Married 2  3 Widowed 4 D		12. Was Deci Armed Fo 1 Tes If Yes, Gir Year or D	2X∏No ve	- 11	Vas Decedent of H I Yes, specify Cuba	lispanic Orig an, Mexican, Specify:	jin? (Speci Puerto Ri	fy Yes or No- can, etc.)		. Race - Ameri Black, White	
	15. D (Specify onl	ecedent's Ec			16a. Deced	ent's Usual Occup	ation	of working		16b. Kind	of Business/Ir	
	Elementary/Secondary		College (	1-4or 5+)	inte. L	NOT use retired	d)	di working		Self-	Employed	i
	17. Father's Name (First, Jo	Middle, Last) Seph Swa					18. Mother	's Name (F	irst, Middle, Harrie	Maiden Su	ımame)	
-	19a. Informant's Name/Re	elationship (7 (Sister)				g Address (Street Quarter Av						7/0
-	20a. Method of Disposition  **Data Control of Disposition  **D	nation 3 🗆	Removal from	01-1-	Place of Dispos		(8)	Date	9	20c. Locat	tion - City or T	
	21. Signatur of Funeral S				22.	Name and Address	ss of Facility	Rol1	ins Fun	eral H	ome.Inc.	
23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Septic Shock  Due to (or as a consequence of):  Bilateral Noscomia					th. Do not ente	r the mode of dyin	g, such as ca	ardiac or re	espiratory arr	est,		Approximate Interval Between Onset and Death
	Sequentially list conditions if any, leading to immedia	s, le	b	or as a conse	quence of);							
	Sequentially list condition if any, leading to immedia cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Side d	b. Due to ( ASpil	or as a conse	Heuroni	a phalopathy						
	that initiated events	ant	b. Due to ( Aspui  c. Due to ( Taxi  d. 23c. If yes, outs 1 Live bi	or as a consection Metabook  come of pregnith 2 Feta ant at time of c	Henoni quence of): plic Free ancy aldeath 3					23d.	. Date of delive	ery Day Year
	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1 ☐ Yes 2★ No 9 ☐ Unknown  Part II. Other significant of	ant ?	b. Due to ( Aspid c. Due to ( Toxid d. 23c. If yes, out 1  Live bi 4  Pregni	or as a consection of as a consection of pregnant at time of a consection of a	Henmi quence of): plic Free ancy al death 3   16	phalopathy  Ectopic pregnancy  Other (specify)	on in Part I.				Month	Day Year
	Lause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1   Yes 2 No 9   Unknown  Part II. Other significant c	ant :? onditions conic Ren	b. Due to ( Aspui c. Due to ( Toxi d.  23c. If yes, out 1 Live bi 4 Pregni 9 Unkno	or as a consection Metabox  come of pregning the 2   Feta ant at time of convenience of the convenience of t	Henmi quence of): plic Free ancy al death 3   16	phalopathy  Ectopic pregnancy  Other (specify)	on in Part I.		1 □ Ye 24a. Was a	pacco use co	Month contribute to the state of the state o	Day Year  the cause of death?  bably 4 Unknown  psy findings available
1	IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1   yes 22   No 9   Unknown Part II. Other significant c Chro	ant onditions conic Remoted Dec	b. Due to ( Aspu c. Due to ( Toxi d.  23c. If yes, out 1 Live bi 4 Pregni 9 Unkno	or as a consection Metabox  come of pregning the 2   Feta ant at time of convenience of the convenience of t	Henmi quence of): plic Free ancy al death 3   16	phalopathy  Ectopic pregnancy  Other (specify)	on in Part I.		1 Ye	pacco use o	Month  contribute to the decision of the decis	Day Year the cause of death? the bably 4 \( \subseteq \text{Unknown} \)
1	Lause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1   Yes 2 No 9   Unknown  Part II. Other significant of Chirco	ant onditions conic Remoted Dec	b. Due to ( Aspiration of the control of the contro	or as a consection Metaborous of pregnish 2 Fetant at time of cown with but not respect to the consecution of the company of t	Henmi quence of): plic Free ancy al death 3 to death 5 to	ctopic pregnancy Other (specify) derlying cause give	26. Place o		1 Yes 24a. Was a autops perform 1 Yes 2	pacco use of section of the section	Month  contribute to the state of the state	Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No
	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1	ant onditions conic Remoted Dec	b. Due to ( Aspiration of the control of the contro	or as a consection Metaborous of pregnish 2 Fetant at time of cown with but not respect to the consecution of the company of t	Henmi quence of): plic Free ancy al death 3   16	phalopathy  Ectopic pregnancy Other (specify)  derlying cause give	26. Place o	ing Home 28d	1 Yes 24a. Was a autops perform 1 Yes 2	pacco use costs of the costs of	Month  contribute to the state of the state	Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No

State Registrar

31. Date filed (Month, Day, Year) AUG 1 6 2005

29b. Signature and title



who con pleted cause of death (Item 23a) (Type, Print)

29c. License number

MD47867

29d. Date signed (Month, Day, Year) August 12, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200528431 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7, 11:10 P M 2005 August Gladys Elizabeth Shelton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Virginia Yrs. 8,1913 October Director 91 577-56-7536 Usual Residence of Decedent filad within 72 hours aftar daath with tha Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State ir than "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Director Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6711 Vermont Ct 20785 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales 6 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pagas 1 and 2 should be file Department of Health and Mantal Hy Important: if Itam 27 is marked oth any liqury or other traumatic event <u>once.</u> Be Lena Belle McDaniel Robert P. Gregan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Hall - Daughter Route 2, Ray City, Georgia 31645 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 8/11/2005 Ft. Lincoln Cem. Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complicate that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Rd. Brentwood, MD 20722 Approximate Interval Between Onset and Death

weeks mmediate Cause (Final weeks **Physician** disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discuss of Min) Due to (or as a consequence of): Examiner The law requires that the death cartificate be executed the attanding physician and had for usa as the burial-transit Causa (Diseasa of it) it that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) cata has baan signad by paga 2 should ba datack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy mea? 2⊡ No cartificata 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🔀 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Pis. 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident after daath Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. within 2 To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D 52298 who comp d cause of death (Item 23a) (Type, Print) 30. Name and address of purson

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Divya Verma, MD

AUG 1 6 2005

31. Date filed (Month, Day, Year)

#202, Greenbelt, MD 20770

7525 Greenway Ctr. Dr.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** August 6, 2005 9:30 PM Smith Lillian /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery **#746** Silver Spring 3701 International Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 2, 1921 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 20 F Mississippi 344-16-4908 84 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State or 28a-f show Examiner count by notified at 1 XYes 2 No Silver Spring Directo Maryland Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 3701 International Drive #746 20906 United States Items 23a death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Mental. 1 Never Married 2 Married 1 ☐ Yes 2 No Yes Give African American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Navy Department Administration Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Pope Ansel Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jacqueline James daughter 8708 Timber Oak Lane, Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 <sup>th</sup> Burial 2 □ Cremation 3 □ Removal from State 8/12/05 Ft. Lincoln Brentwood, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signatury of Funeral Service Livensee 22. Name and Address of Facility McGuire Funeral Service 23a. Part1. Enter the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Just only one cause on each line. 7400 Georgia Ave. N.W., Wash. D.C. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years Coronary Artery Disease resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 3 ☐ Probably 4 🕍 Unknown 1 ☐ Yes 2 ☐ No Atrial Fibrillation Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an med? 2 X No 1 🗌 Yes **∑** No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident in by the 1 Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours after on Funeral Direct 4 | Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of co cause of death (Item 23a) (Type, Print) 30. Name and addre Nakul Goyal, M.D. 3801 International Drive Suite 211, Silver Spring, MD Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

AUG 1 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005

			1 = For State Registrar	State of Mar		tificate of			giene <b>z (</b> Reg. No.	000	28433
Š	Physic	ian	1. Decedent's Name (First, Middle, Las					2. Date of De Month		Year	3. Time of Death
	/Medi	cal	William H. Smit					August	11, 20	05	1:25 PM
	Exami	ier	4a. Facility Name (If not institution, give Hospice of the C			4b. City, Town, C	or Location of Dea	ath		ty of Death	
20.0	Funeral		5. Social Security Number 6. Se		In yrs. last birthday)	Jf Under 1 Year	IM If Under 24 Hr	S. 8 Date of Bird		Arund	
9	Director		579–36–5599 <sup>1</sup> Usual Residence of Decedent	M M O C	4 Yrs.	Months Days	Hours Mir	Nov. 16	, Year) 1930	Washi	lace (State or Foreign try) .ngton, DC
	yland		10a. State 10b. County	1	Oc. City, Town or Lo	cation		·		10	0d. Inside City Limits
	B Mar	ctor	Maryland Prince	Georges	Bladensbu	rg					1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	try?
	s 23e	rai	4202 58th Avenue			20710			United		
336	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other then "naturel", or Items 23a or 28a-f show imatic event, the Wedical Evantier must be notified as	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	lf	Vas Decedent of H Yes, specify Cub ☐ Yes 2 🛣 No		Specify Yes or No- into Rican, etc.)		ace - America ack, White, e	<sup>an Indian,</sup> etc. <b>merican</b>
Š	2 hou	ted	15. Decedent's Ed	ucation	16a Deced	ent's Usual Occup	pation		16b. Kind of		
215	thin 7 en 'n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give I	kind of work done O NOT use retire	during most of we d)	orking	700.10.10	2001100041110	asny
21	ygien ygien rer th	Соп	Elementary/Secondary (0-12)		Paint	er			NIH		
Maryland 21215-0036	should be filed wand Mental Hygiers and Mental Hygiers amarked other thumatic event, the	Be	17. Father's Name (First, Middle, Last) Nepoleon Smith					ame (First, Middle,	Maiden Suma	ime)	
Š	hould id Mer mark matic	2	19a. Informant's Name/Relationship (7	vna Print)	10h Mailine	Address /Ctract		Hammond  Rural Route Numbe			
<u>8</u>	nd 2 s ith an 27 ls r treu	H		/ Brother				washing.			Code) 0020
ē,	item othe		20a. Method of Disposition		20b. Place of Dispos cemetery, crem			Date	20c. Location		
Ē	Page nent o ant: If ary or		1  Burial 2  □ Cremation 3  □  3  4  □ Donation 5  □ Other (Specify		Harmony M			18/05	Landove	er. Ma	rvland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic a <u>once</u> .		21. Signature of Funeral Service Licens	100			ss of Facility Mc	Guire Fu	neral S	Servic	e .C. 20012
п	7		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the							Approximate
	Physician		Immediate Cause (Final disease or condition		te Cancer						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a co							
	Examiner		Sequentially list conditions.	b							
	ed isi	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):						
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of):						
08/0 <b>0</b> ,	e be e siciar e buria	caiE		ď							
Q	± 0, ∞	ledicai		J							
. BOX	death ce	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3 E	Ectopic pregnancy Other <i>(specify)</i>				ate of deliver	y Day Yéar
ŗ	that the	Δ.	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the unc	dertving cause give	en in Part I	23a. Did to	nacco usa con	tribute to the	cause of death?
Solos	requires	Q				, 3					bly 4 Hunknown
ם ום	ala has e2	Completed						24a. Was a autops perform	y	Were autops prior to compleath?	sy findings available pletion of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	sicien: The certificate l irector, pag	Be	25. Was case referred to medical examiner?	Ja anitali				ath (Check only on	e)		
5	Phys this ral dir	2	1 ☐ Yes 2 X No  27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient	3 DOA Othe	er: 4 ☐ Nursing H	fome 5 Reside	nce MOt	ner (Specify)	hospice
5 :	ding Phy th. : After thi funeral	ţ	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) 28b. Time of Injury	28c. Injun Work	Yes 2 □ No	28d. Describe ho	w injury occur	red	
2	l or Attendi after death. Director: //	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	At home, farm, stree		700 2 110	28f. Location (St	reet and Numi	ber or Rural I	Route Number
5	s afte s afte el Dir	Cert	4   Homicide	building, etc. (S	specify)			City or Towr	, State)		
:	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Medical	29a. Certifier 1 Certifying Phy one) 2 Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated.	arimiation ariozor inve	occurred at the tim stigation, in my op	e, date and place pinion, death occu	a. and due to the caurred at the time, do	use(s) and mate and place,	anner as stall and due to th	ad he cause(s)
1	To the comp	ž	29b. Signature and title of certifier	1		29c. License	number	25	d. Date signe	d (Month, Da	ay, Year)
	1		1 le un fo	en		D0057	7680	A	ugust	12, 20	05
R	-(10)		30. Name and address of person who								
40	Stat	0	Brett Kolpan, M.D. 31. Date filed (Month, Day, Year)	2 Registrar's	th Way, Su		Maryland	1 20746			
	Registra	•	AUG 1 6 2005	Blow	& Sport	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28434 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 13 Year Sandra K. Sanderson 243 A M AUGUST /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE HOSPITAL OF 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 7, 19 n/a 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 M 2 € F 219-44-8026 Director 1945 Maryland Usual Residence of Decedent 10b. County 10a. State 28a-fehow 10c. City, Town or Location 10d. Inside City Limits la markad other than "natural", or Itame 23a or 28a-f ehov raumatic evant, the Medical Examinar must be notified at Directo 1 ☐ Yes 2 No Maryland Cecil Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Russell Road Funeral 21917 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Reddish Elizabeth Burd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Sanderson/Husband 212 Russell Road, Colora, MD 21917 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 \( \) Burial 2 \( \) Cremation 3 \( \) Removal from State \( \) 4 \( \) Donation 5 \( \) Other (Specify) West Nottingham Cem. ! 8-18-2005 Colora, Maryland 22. Name and Address of Facility
R. T. Foard Funeral Home, F.A.
111 S. Queen St., Rising Sun, MD 21911 21. Signature of Funeral Service Licensee 23 Part1. Error the disease, or corp lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MULTI- ORGAN Physician SECONDARY FAILURE resulting in death) /Medical Examiner TASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed as the burial-transi Exam resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death Year signed by the a 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 13, 2005 D0063500 Christian Ministrall MD PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE CHRISTIAN MINSHALL MO PhD 31. Date filed (Month, Day, Year) State AUG 1 6 2005 Registrar

DHMH 17 Rev 1/2001

SANDERSON

SANOKA

FNOWN AS

PATIENT

			1- For State Registrar Amend #18	State of M 8,8/22/05, p	Marylan ber FH	nd / Depa	artmen	t of H e of L	ealth a	and N	nental H	ygien	20	05	28435
	°0		1. Decedent's Name (First, Middle,			HCHE	, dk	0 0, 1			2. Date of [	Reg. N			3. Time of Death
	Physic /Medi		Mildred L. Sut	ter							Month Augus		ay 5 20	Year 005	8:30 A <sup>M</sup>
	Exami		4a. Facility Name (If not institution,		er)		4b. City,	Town, or	Location o	of Death	nugus			y of Death	0.30 A
			7431 Swan Point				Colu					ŀ	lowai	rd	
п	Funeral		5. Social Security Number	6. Sex 7. / 1 ☐ M 2 X F	Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of E (Month, L	irth Day, Year	r)	9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent			84 Yrs.					Dec 12			New	
	yiand now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	10d. Inside City Limits
	Mar B-f st	to	New York Suffol	k	Rid	90									1 Yes 2 No
	or 28	Director	10e. Street and Number		1 22 3	<del></del>	10f. Zip	Code				10g. C	itizen of	What Cour	ntry?
	23a	la	1302-B Village D	rive			1196	61				USA	7		
	er deg	by Funeral	11. Marital Status	12. Was Deceder Armed Forces	<b>\$</b> ?	.S. 13. V	Was Deced	ent of His	spanic Orig	gin? (Sp.	ecify Yes or N Rican, etc.)	0-		ce - Amend	
36	rs afte	y F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates		1	I□Yes 2	37	Specify:					<sup>ʻy:</sup> Whi	
Ö	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ite Marical Evantine right to invitified at	ed	15. Decedent's			16a. Deced	lent's Heur	I Occupa	tion			105			
215	nin 72	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	- 5 - \	(Give	kind of wor OO NOT us	k done di	urina most	of work	ing	160. 7	Kina of B	usiness/Ind	Justry
21	d with giene. er thar	Completed	Clomoniary/Secondary (0-12)	College (1-4o 2	or 5+)	Homema	aker					Own	Hon	ne	
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 Ia marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ite M. Alcal Examinar must be inviffed at	Be (	17. Father's Name (First, Middle, La	ast)							e (First, Middl				
yla	2 should be f and Mental I la marked of raumatic eve	P	Michell Regina					]	Lilly	Far	antino	Fer	rren	tino	
Лaг	2 sh and lam raum		19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	al Route Num	ber, City	or Town,	State, Zip	Code)
	of Health item 27		Eugene A. Sutter	/son	loot D	7431 8	Swan I	Point		-	umbia,	MD	2104	-5	
altimore,	if ite		20a. Method of Disposition 1 □ Burial 2 ☒Cremation 3		e C	lace of Disposemetery, crem	natory or other	ner place		-	st 17,	20c. L	ocation -	- City or To	wn, State
Ħ	it. Partitude		* 4 □ Donation 5 □ Other (Spe		W.	Arunde			•		05				ryland
Ba	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Lin	Ha Otto		Gc	Name and	l Address Home	of Facility Crem	atio	n Serv	ice	P.0	. Box	× 784
			23a. Part1. Enter the disease, or co	omplications that cause	ed the death	1251 Be	everly	Z I.	Heck:	rott	e, P.A	· C1	arks	ville	MD 21029
	Physician		Immediate Cause (Final	nly one cause on each	line.			-,3	,						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Congest Due to (or a	ive H	eart F	ailur	e							
	Examiner		Constitution for the first of t	b. Chronic			c Len	kemi	а						
	D #	ner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Que to (or a	e a consequ	rened of):	c Leu	recini							
	ecute ind frans	Examiner	that initiated events	c				_							
8760,	cate be executed bhysician and the burial-transit	Ë	resulting in death) Last	Due to (or a	s a consequ	ience of);									
387	icate be executed physician and the burial-transit	dicai		d											
9 X	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	e of pregnar	ncv						T			
Вох	leath atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3□	Ectopic pre					17	23d. Dat Mor	te of deliver nth	ry Day Year
o.	that the death led by the atter detached for u	hysi	1 ☐ Yes 2 🎇 No 9 ☐ Unknown	9□ Unknown				J., J.							
ري م	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions	s contributing to death	but not resu	Iting in the un	derlying ca	use given	n in Part I.		23e. Did	tobacco	use contr	ribute to the	e cause of death?
rd	w requires t been signe should be	edt									10	Yes 2	□No	3 ☐ Proba	ably 4 ⊠Unknown
Records,	law re as be 2 sho	piet									24a. Was		24b. V	Vere autop	osy findings available
		Completed									auto perfe	psy ormed? 2 <b>X</b> No	C	death?	npletion of cause of 2 □ No
Vita	yaician: Th	Be (	25. Was case referred to medical examiner?						26. Place o	of Death	(Check only			103	2 140
<u>}</u>	S S E	2	1 ☐ Yes 2X No	Hospital: 1   Inpati		R/Outpatient	3□ DOA	Other	4 □ Nurs	sing Hon	ne 5 🗆 Resi	dence	6 XOthe	er (Specify)	Son's
n C	ding Ph h. After thi funeral	ion	27. Manner of Death 1 □Xatural 5 □ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	11	c. Injury a Work?	at	2	8d. Describe	how injur	у оссиги	ed	поше
Division of	Attending ir death. ector: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	t be	A. b		M		es 2 N	-		_			
<u>&gt;</u>	l or Attendate after death Director:	Certification:	4 Homicide determine	28e. Place of In building, e	itc. (Specify)	ne, tarm, stree	et, factory,	office		2	8f. Location ( City or To	Street an wn, State	d Numbe )	er or Rural	Route Number,
_	To the Mospital or A within 24 hours after To the Funeral Dire completely filled in by		29a. Certifier 1 XCertifying I	Physician: To the best	t of my know	vledge death	occurred at	the time	date and	nlace o	nd due to th-	031105/51	and	nnor no et	****
	ne Ho 124 h ne Fu	edicai	(Check only 2 Medical Ex	taminer: On the basis of and manner st	ui examinati	on and/or inve	stigation, in	n my opir	nion, death	occurre	d at the time,	date and	i place, a	ind due to	the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	) ()			29c. l	License r	number			29d. Dat	e signed	(Month, D	Pay, Year)
6	0		Jaca)			_	D50	0973				۸ ، ۱ ، ۲ ، ۲	ct 1	6 20	O.F.
4)	8.6-		30. Name and address of person wh											6, 20	0.5
y			Jacob Cheri				rth D	r. #	310 C	co1ur	nbia, M	D 21	045		
	Star Registra		31. Date filed (Month, Day, Year),	2005 32. Registr	rar's Signatu		endid								
							-								

		1 - For State Registrar	State of Maryland / Dep	eartment of Health and ertificate of Death		2005	28436
		Decedent's Name (First, Middle, Las			2. Date of Death Month	Day Year	3. Time of Death
Phys /Me	ician dical	GERALDYNE	D. Tyson			3TH 2005	8:25 M
	niner		LYLAND HOSPITAL	4b. City, Town, or Location of De  CLINTON  If Under 1 Year   If Under 24 H	3		GEORES
Funer Directo		5. Social Security Number 6. Sec. 1	7. Age (In yrs. last birthday		Irs. 8. Date of Birth (Month, Day, Y	(enr) Coui	place (State or Foreign htry)
D.		Usual Residence of Decedent			10 /24/		
with the Maryland a or 28a-f show	5	10a. State 10b. County	10c. City, Town or I				10d. Inside City Limits 1 Yes 2 □ No
the M	Director	10e, Street and Number	NEW	10f, Zip Code	100	. Citizen of What Cou	
h with	io	470 LENOX	AVE.	10037	7	USA	
after death w or Items 23s	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Americ Black, White,	
	by Ft	1 Never Married 2 Married 3 Widowed 4 Divorced	1  Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: 12	ACK.
72 hours "naturaf",	ted	15. Decedent's Ed	ucation 16a. Dec	edent's Usual Occupation	16	b. Kind of Business/In	
ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)		e kind of work done during most of v DO NOT use retired)	working	HEALTI	
filed w Hygier other th	e Cor	12 YRS. 17. Father's Name (First, Middle, Last)	0 1	URSE 18. Mother's N	Name (First, Middle, Ma	CARE	•
d be d be contained	o Be	7	SON	VIVIA		VIS	
ary shoul and Me s mark	-	19a. Informant's Name/Relationship (7	ype, Print) 19b. Mai	ling Address (Street and Number or		New York I was a second of the	Code)
re, M s 1 and 2 f Health ( item 27 i		WINSTON HOLL		1 HOOD ST. T.	AKOMA Y		20912
O 8° = 5		20a. Method of Disposition  1 Burial 2 Cremation 3	Hemoval from State	ematory or other place)	Date 20	SILVER	Spring
ITIM iit. Pa artmen artant: injury		* 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	GATE O	F HBAVEN   8 1 22. Name and Address & Fedility 15 0 H N	1/9/2005	mak	VLAND
Dairti. 1 Departm Importal	SUCE		medel	JOHN 7. RAIN	115 1.16	SH DC	20017.
		23a, Pay. Enter the disease, or composh ck, or heart failure. List only	olications that caused the death. Do not a	ner the mode of dying, such as card	diac or respiratory arres		Approximate Interval Between
Physicia	an	disease or condition	a. Coronary	artery disea	16.		Onset and Death
/Medica	_	resulting in death)	Due to (or as a consequence of)	J	•		
4	ш.	Sequentially list conditions,	b. ALLIYATIC	n pheumoni	$\alpha$		
uted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c				
D, e exec ian an urial-tr		resulting in death) Last	Due to (or as a consequence of):				
Ords, P.O. BOX b8/b0, requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dicai		d				
BOX bi	Φ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	erv
death cer death cer e attendir d for use	Physician/M	in the past 12 months?	4☐Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
that the death hed by the attended for a	hys	9 Unknown	9□ Unknown	ULL-1892	1	1	
igned be de	þ		ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to t 2.XNo 3 ☐ Prot	ne cause of death?
HeCOFGS, Phe law requires that a has been signed to ge 2 should be deti	ompleted				24a. Was an		ppsy findings available
has has	I du	<u> </u>			<ul> <li>autopsy performe</li> </ul>	prior to co death?	mpletion of cause of
VITAL PRINCIAN: The certificate rector, pag	O	25. Was case referred to medical		26. Place of I	1 ☐ Yes 2 Death (Check only one)	¶No 1□Yes	2 <b>2</b> No
Q3	To B	examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing	g Høme 5 ☐ Residen	ce 6 □Other (Specia	<b>(y</b> )
ring and		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred	
DIVISION ( I or Attending F after death. Director: After fin by the funer.	Certification:	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No	28f. Location (Stre	et and Number or Run	al Route Number,
DIV after after Direct	ertif	4 Homicide determined	building, etc. (Specify)	nicot, iactory, onico	City or Town,	State)	
DIVISIO  To the Hospital or Attend within 24 hours after death.  To the Funeral Director: A completely filled in by the fi	dicai	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowledge, dei liner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plainvestigation, in my opinion, death or	ace, and due to the cau ccurred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	1	29c. License number		. Date signed (Month,	
		1.4ha	huin au	D005	2949	8/15/	3007
)			completed cause of death (Item 23a) (Type	RRATTS ROAD	205 CL	INTON	MD 2072C
	State	ALI RAHIMIA  31. Date filed (Month, Day, Year)	32. Registrar's Signature	KKAIII KUAD	200		CC 1 20 0111
	State istrar	AUG 1 6 2005	32. Registrar's Signature	the same of the sa			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 9 0 0 5 28437 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Zenobia Morales Tococari de Bustos August 11, 2005 9:20 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Days Hours Months 1 □ M 2 🛣 F 231-85-7278 65 Yrs. Director September 5, Uncia, Bolivia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "naturel", or Items 23a or 28a-f shov the Medical Examinar must be notified at 1 ▼Yes 2 No Director Maryland 1 Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10n. Citizen of What Country? 204 Hannes Street 20901 Uncia, Potosi, Bolivia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Bolivian 1X Yes 2□ No Specify: Hispanic þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within intent of Health and Mental Hygiene. Int: If item 27 Is marked other than " mentary/Secondary (0-12) College (1-4or 5+) 12th grade Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pastor Morales Zunilda Tococari 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Bustos Velasco (nusual)

Jackeline A. Bustos (Daughter) 204 Hannes SLI

200. Place of Disposition (Name of cometery, crematory or other place) 19a Informant's Name/Relationship (Type, Print)
VICTOR Bustos Velasco (Husband) 204 Hannes Street; Silver Spring, Maryland 20901 Date 20c. Location - City or Town, State 8-18-05 5 permit. Page Department o Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Cementerio General de Tiquipaya Tiquipaya, Bolivia 21 Signature of Funeral 22 Name and Address of Facility
Santa Cruz Funerarios Servicios 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 600 Kennedy Street, N.W.; Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction 5 minutes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) ally, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) Box 68760, physician death certificate be Physician/Medicai the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 X No ţ Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the i 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ be Chronic Kidney Disease 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ဂ္ 2 K ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After To the Hospitel or Attending 5 Pending within 24 hours after death. To the Funerel Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D20400 August 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark S. Rosen, M.D.; 3941 Ferrara Drive; Wheaton, Maryland 20902

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 6 2005

2. Registrar's Signature

			1 - For State Registrer	State of Marylar		artment of F			iene 2005	28438
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat	h	3. Time of Death
	Physic /Medi		Robert	Bailey		Tak	ob	August	Day Year 15,2005	2:36A M
	Exami		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or			4c. County of Death	2:36A
			Charles Co.NSG	& Rehab Ctr		LaPlata	1		Charles	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24		9. Birth	place (State or Foreign
	Director		225-20-2724	M 2□F 82	Yrs.	WOTHIS Days	Hours		19,23 Vir	ginia
	and w	]	Usual Residence of Decedent  10a, State 10b, County	10c Cit	ty, Town or Lo	nation				
	Aarylan f show	ō								10d. Inside City Limits 1 ☑Yes 2 ☐ No
	28a-	Director	Virginia  10e. Street and Number	Net	wport	News 10f. Zip Code				71
	with Ba or	ā		7 - L 7		236	0.7	10	og. Citizen of What Cou	ntry?
	72 hours after death with the Maryland Insturel; or Items 23a or 28a-f show disal Exanding must be invitted at	Funeral	1210 20th St.	APT . A  12. Was Decedent Ever in U	S 13 1			2 /Specify Van as Na	USA 14. Race - Americ	
10	ritar	돌	1 Never Married 2 Married	Armed Forces? 1 XYes 2 No	13.	f Yes, specify Cuba	n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Black, White,	
99	urs a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛛 No	Specify:		Specify: Bla	ack
21215-0036	72 ho	Completed	15. Decedent's Ed	ducation	16a. Deced	ient's Usual Occupa	ation	1	6b. Kind of Business/In	
215	S 2 3	ple	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done o OO NOT use retired	furing most of )	working		,
2	filed with Hygiene. other ther	NO.	12		Skil	led Lab	or	C	onstructi	.on
p	be filed tal Hyg d otha evant,	Be (	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, M	laiden Sumame)	
Maryland		0	Zack	Tak	obd		Virg	inia	Baile	РУ
a	- 00 00 -		19a. Informant's Name/Relationship (				and Number o	r Rural Route Number,	City or Town, State, Zip	
	ss 1 and 2 should of Health and Men item 27 Is marks other traumatic		Alice Hawkins/		9400	Penns H	ill R	d, LaPlat	a Marylan	d 20646
	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		lace of Dispo	sition (Name of natory or other place		Date 2	0c. Location - City or To 230	own, State
<u> </u>	Pages ment of lant: If it		'4 Donation 5 Other (Specific		tle E	lam CH.	Cem 8-	-20-05 C	harles Ci	ty Va
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer			. Name and Addres				•
_	<u> </u>		Llught &	1	91 Ad	ams Fun	eral I	Home PA, A	quasco MD	20608
н			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the deatl one cause on each line.	h. Do not ente	er the mode of dying	, such as care	diac or respiratory arre	st,	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	. 56	0051	S				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					a weeks
	LAGIIIIIIEI		Sequentially list conditions,	b						
	sit sit	Examiner	cause. Enter Underlying	Due to (or as a con	usince of):					
	ecute and tran	(am	Cause (Disease or injury that initiated events resulting in death) Last	c						
9	be ey cian burial	E		Due to (or as a consequ	uence or);					
68760,	ficate be executed physician and is the burial-transit	dlcal		d						
	death certific attending p	0	IF FEMALE:	23c. If was outcome of progna		-				
Вох	death certifie attending at for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	I death 3	Ectopic pregnancy			23d. Date of delive Month	ry Day Year
P.0.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eatn 5□	Other (specify)				Day Tour
۵.	Ine law requires that the de ate has been signed by the a page 2 should be detached f	Ph.	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the un	derlying cause give	n in Part I	23e Did toba	cco use contribute to th	a cause of death?
Records,	sign d be	d by	Bladdar	Cancer	<b>3</b>			1 ☐ Yes		0.1
Ö	w requir been si should	ete		-				_		Activition 1
ě.	has ge 2	Completed	Neutroper	10				24a. Was an autopsy performe	prior to con	osy findings available npletion of cause of
			05.14					1 ☐ Yes 2	No 1 ☐ Yes	2□ No
Vital		) Be	25. Was case referred to medical examiner?	Hospital:		Othe		Death (Check only one)		Text I ex
ō	£ ± ₽	o L	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ I	ER/Outpatient 28b. Time of	3 DOA 28c. Injury	4 Nursin		ce 6 □Other (Specify	)
0	After funer	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work'	es 2 □No	28d. Describe how	injury occurred	
ISI/	or Attending Progression death.  Diractor: After the in by the funeral	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, stre		33 2 110	28f Location (Stre	et and Number or Rural	Pouto Mumbos
	E 5 5 5	erti	4 Homicide	building, etc. (Specify	')	or, ractory, ornos		City or Town,	State)	rioute Number,
	o the nospital of Attending within 24 hours after death. To tha Funaral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phy	/sicien: To the best of my know	wledge, death	occurred at the time	a, date and nis	ace, and due to the com	so(s) and manner as	atod
=	n 24 h	Medical	(Check only 2 Medical Exemone)	iner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my opi	nion, death of	ccurred at the time, date	and place, and due to	the cause(s)
1	within 2 To tha comple	ž	29b. Signature and title of certifier			29c. License	number	290	I. Date signed (Month, D	Day, Year)
			1 4. duesso			150	5455	5	8/15/05	
0			30. Name a d ad ress of person who d	ompleted cause of death (Item	23a) (Type, F	Print)				
Ы	331		Fatina Y. Hus	ompleted cause of death (Item SELO 56 25	Allen	Lown R	d # 10	of Camp	Springs.	mo an xi
	Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Signat	ure			1	The in city	11.20 010776
	Registra	ar	AUG 1 6 2	UUD SIMPLE	1 4	nauli s				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 14, 2005 6:00 A Beverly Hall Van Horne August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's 15701 Main Blvd. Accokeek f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 2, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1√2√M 2□ F 88 Michigan Vre Director 104-22-6677 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28e-f show s 23a or 28e-f sho 1 ☐ Yes 2 No Prince George's Maryland Accokeek Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15701 Main Blvd. 20607 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status The Medical Examiner: perrit. Pages 1 end 2 should be filed within 72 hours after to Department of Heelih and Mental Hygiene.
Importent: if item 27 is marked other then "natural; or tles any njury or other treumatic event, the Medical Examinat 1 ☐ Never Married 257 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Research / Teaching 5+ Physicist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Orson Van Horne Myrtle Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7317 Olive Tree Ct. Gaithersburg, MD 20879 Jon W. van Horne / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 19, 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State <sup>4</sup> □ Donation 5 □ Other (Specify) 2005 Frederick, Maryland Resthaven Mem. Gardens 21. Signature Funeral Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 1. Enter the disease, or ck, of bear failure. List Immediate Cause (Final disease or condition VANCED Pnysician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner nding physicien and use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter Month Year in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 X No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 4 Nursing Home 5 sidence 6 ☐ Other (Specify) 2**X** No 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of of or Attending Patenting Certification: 5 Pending investigation Natural 2 🗌 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospitei of within 24 hours of To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signarifre and title of certifie 29c. License number 00 7 of person who comple ed cause of death (Item 23a) (Type, Z061 31. Date filed (Month, Day, Year) State 4000 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28440 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician ARUL 0935 ALEN 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake House Anne Arundel Linthicum If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 15, 1944 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 1 M 20 F 146-34-3450 61 **Director** Usual Residence of Decedent death with the Maryland 7.7 is marked other then "naturel", or Items 23a or 28a-f show treumatic event, the Modical Exerting must be rightled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📆 No Director Anne Arundel Odenton 0 0 1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Quiet Pond Court 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then 'any injury or other treumatic event. If w Ms. Elementary/Secondary (0-12) College (1-4or 5+) 5+Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Baker Esther Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan G. Van Dalen / Son 709 Quiet Pond Ct. Odenton, MD. 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 08/16/2005 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licen 6512 NW Crain Highway Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Dualto (or as a consequence or) Examiner cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably Completed 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 No 1 Yes 2 🗆 No 1 Tes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 One O 1 Yes 2 No 7 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Aq 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the within 24 Signature and title of certifier 29d. Pate signed (Month, Day, Year) (14 Name and address of leted cause of death (Item 23a) (Type, Print) no un nicHAZZ 4 31. Date filed AUG 1 Registrar's Signature State 6 2005 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#11,perinf C847,9/13/05 TT
State of Maryland Department of Health and Mental Hygien 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** WOLA VICKERS 5:00 P 2005 August /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Kent Chestertown Chester River Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 ☐ M 2 🕅 F Virginia June 1, 1904 101 Director 039-20-0234 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other then "neturel", or items 23s. or 28e-1 show any injury or other traumatic event, the Mcdical Expire or must be referred. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Queen Anne's Church Hill MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21623 225 Crane Swamp Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nettie Peachie Utz Franklin Monroe Sampson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 235 Crane Swamp Road, Church Hill, Maryland 21623 John Thomas Steele, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 08/16/2005 Brentwood, Maryland 4 ☐ Dorlation / 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Sign sture of Furneral 5, rvice Licens 4739 Baltimore Avenue, Hyattsville, Maryland 0 23a/Part Enter the disease, or complications of taused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused line. Approximate Interval Between Onset and Death Immediate Cause (Final multiple Physician Or disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine the attending physician and the dor use as the burial-transition Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by (3) 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1611. Ulum, MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · Clestertown, MD 21620 KIN K. WUN, 415 Washington 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 6 2005 Registrar

CPM 05-05454 Lance Wishart

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2 0 0 5

		For State Registrar		Ce	rtificate d	of Death	2. Date of De	Reg. No		10 T 10
sician		Decedent's Name (First, Middle, Las Lance John Wishan					Month Augus		Ž, 2ŎO5	3. Time of Death 17:10 M
edical		a. Facility Name (If not institution, give			4h City Tow	n, or Location of D			. County of Death	17.10
miner		205 Market Street			Den	ton			Caroli	ne
ral tor	Ŀ	132-36-9394	7. Age	(In yrs. last birthday)	Months Da		Hrs. 8. Date of Bir Min. March	$\frac{1}{7},\frac{7}{9}$	9. Birthp Cour 1961 New	place (State or Foreign otry) Jersey
4	-	Jsual Residence of Decedent  Oa. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits
y Funeral Director	I	Maryland Card	oline		Dento	n				1 HY6s 2 No
Sire	1	0e. Street and Number			10f. Zip Cod			10g. Cit	izen of What Cour	nt <b>ry</b> ?
<u></u>	L	205 Market St.,	-		2162				USA	
by Funeral Director	1	Marital Status     Never Married 2 Married     Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	0	Was Decedent If Yes, specify ( 1 ☐ Yes 2 ☑		' (Specify Yes or No Jerto Rican, etc.)	D-	14. Race - Americ Black, White, Specify:	etc.
ed b	-	15. Decedent's Ed	Year or Dates:		dent's Usual Oc	cupation		16b K	ind of Business/In	White
Be Completed	-	(Specify only highest grad	le completed) College (1-4or 5-	(Give	kind of work do DO NOT use re	ne during most of tired)	working	100.10	WIG OF DUSINGS 3/11	adatiy
ĕ		12	College (1-401 5-		imployed	Carpet	Installer	C	onstruct	ion
Be (	1	7. Father's Name (First, Middle, Last)					Name (First, Middle			
2		Rodney Wishart					exandra S			
To Be Completed by		19a. Informant's Name/Relationship <i>(1</i> Jeannine Marie Wis			-		Rural Route Numb	-		
	11-	Oa. Method of Disposition	silar t/ wire	20b. Place of Disponentery, cre			enue, Cam		cation - City or To	
	ľ	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify				1	/22 /200E		,	
	1	21. Signature of Funeral Service Licen		MD Vetera		dress of Facility	/ 23/ 2005	HU	rlock, M	D
ä	1	H. Lourson-	Xenie!	200 5	urran-E	romwell	Funeral H	ome,	2P643	
		23a. Rant Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. Do not en	ter the mode of	dying, such as care	diac or respiratory a	rrest,	21013	Approximate Interval Between
	-	mmediate Cause (Final disease or condition resulting in death)	a CONTAC		LOT W	NOUNO OF	KEAL	)		Onset and Death
		1	Due to (or as a	consequence of):						
ē	1	Sequentially list conditions, ary, leading to inmediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):						
Examiner	0	cause. Enter Underlying Cause (Disease or injury that initiated events								
		esulting in death) Last	Due to (or as a	consequence of):						
Aedical			d					_		
Med	1	F FEMALE:								
lan/	1	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 ☐ Fetal death 3	Ectopic pregna				23d. Date of delive Month	Day Year
Physician/N		1 Yes 2 No	4□Pregnant at t 9□Unknown	time of death 5	Other (specify	)			77.07.11.1	Duy Tour
Š	۱,	art II. Other significant conditions co	ntributing to death bu	t not resulting in the u	inderlying cause	given in Part I.				ne cause of death?
ted	-			•			_ 10	Yes 2,	Mo 3 ☐ Prob	ably 4 Unknown
Completed	-					<del></del>		psy ormed?	prior to con death?	psy findings available mptetion of cause of
		5. Was case referred to medical				26 Place of I	152 Yes Death (Check only o		1,⊠Yes	2□ No
To Be		evaminer?	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatier	nt 3 DOA	0.1	g Home 5 ☐ Resi		Specific	SCENE
	2	7. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injun	Year! Injury	f 28c. I	njury at Work?	28d. Describe	how inju	y occurred	
atic		2 ☐ Accident investigation	HOUND at a t	05 FOUND 4:		☐Yes 2 🕅 Vo	SVBTE	द	smot se	4
Certification:		3 ☑ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc. RES 1 0		reet, factory, offi	се	City or For	wn, State	d Number or Rura	111
Medical (	1	29a. Certifying Phy (Check only one) 2 Medical Exam	sician: To the best o	f my knowledge, deat examination and/or in	h occurred at th	e time, date and pl ny opinion, death o	ace, and due to the courred at the time,	cause(s) date and	and manner as si place, and due to	lated. the cause(s)
Me	2	9b. Signature and title of certifier	and manner star		29c. Lic	ense number		29d. Dat	te signed (Month,	Day, Year)
		) and	(			O.C.M.E			ust 13,	
					2			_	•	
	3	0. Name and address of person who c	ompleted cause of de	ath (tiem 23a) (Type	Penn S	treet. B.	altimore.	Mar	vland 21	201

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend/Unpend item#1223a 27 perMF G850 12-23-05 TT State of Maryland Department of Health and Mental Hygien 2 0 5

28443

							niiicai	e or L	Death			Reg. No	).		Y	
ysician	1.	Decedent's Name (First, Middle		******		-				1	2. Date of De Month	Da	Ď, :	Year	3. Time o	
ledical	4:	Craig Sylva. Facility Name (If not institution)		Willia	ums,	Jr.	4b. City.	Town or	Location of I	Death	August		. County	2005 of Death	00:0	) A'''
aminer	46	Calvert Memoria							Frede		c			alver	ct	
eral	5.	Social Security Number	6. Sex		(In yrs. I	last birthday)	If Under	r 1 Year Days	If Under 24 Hours	Hrs.	B. Date of Bir (Month, Da	th v. Year	)	9. Birthp	lace (State o	or Foreign
or		215 98 4460	1 → M 2			38 Yrs.		54,0	110010		Jan 24				ingtor	
Irector	-	sual Residence of Decedent  0a. State 10b. County			10c. City	y, Town or Lo	ocation							1	0d. Inside C	ity Limits
ō		Maryland Calver	rt.			Ниг	nting	tour							1 🗆 Yes	2 No
Director	-	0e. Street and Number	. C			IIUI	10f. Zip					10g. Ci	tizen of W	/hat Coun	ntry?	XX
		1220 Ho	ollyber	rry Cou	ırt			20	639			Ţ	Jnite	d Sta	ates	
Funeral	1	1. Marital Status	Arr	as Decedent 8 med Forces?		.S. 13.	Was Dece	dent of His	spanic Origin n, Mexican, F	? (Spec	ify Yes or No ican, etc.)		14. Race		an Indian,	
by Fu		1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 📆 Øivorced	ied 1 [	∃Yes XXX N Yes, Give	lo		1 🗌 Yes		Specify:				Specify:	Wh	ite	
ed b	-			ear or Dates:		16a. Dece	dent's Usu	al Occupa	ition	<del></del>		16b. K	(ind of Bu			
Completed	-	15. Decedent (Specify only highes				(Give	kind of wo	ork done d ise retired)	uring most o	f working	9					
mo;		Elementary/Secondary (0-12)	Co	ollege (1-4or 5	+)	E1e	evator	r Mec	hanic			E1	con			
Bec	1	7. Father's Name (First, Middle, I									First, Middle,	Maider	Sumam	e)		
2		Craig Sylve			is, S						Davis					
	1	9a. Informant's Name/Relationsh		•							Route Numb		or Town, :	State, Zip	Code)	
	2	Louise Willia Oa. Method of Disposition	ıms (mo	otner)	20b. P					nian Da	MD 20		ocation -	City or To	wn, State	
		1 ☐ Burial XX Cremation		al from State	5_	Place of Disponentery, crea								,	, orace	
	2	4 Donation 5 Other (Sp. 21. Signatur Funer Sprice)		/	ree	Crema					Tunera	CTI	nton	• MD	522 A1	.a
		Mush	9/1	/ kg	20 74	< 3 A	1exar	ndira	Ferry	Rd	, Clint	on.	MD 1	20735	222 01	u
	ſ	disease or condition esulting in death)		omplica Due to (or as	ting	hyper			cirrho					ascu	Onset and	
Examiner	r		b		nting a consequ	hyper uence of): uence of):		and						ascu	Onset and	ween Death
clan/Medical Examiner	S id oc C	esulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying Jause (Disease or injury hat initiated events	b	Due to (or as	a consequence a consequence of pregna 2   Fetal	uence of):  uence of):  uence of):		and ive a					diov	e of delive	Onset and lar di	ween Death
by Physician/Medical Examiner	s id co	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Jause (Disease or injury hat initiated events esulting in death) Last  F FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	b	Due to (or as a Due to (or a))))))))))))))))))))))))))))))))))))	a consequence of pregna 2 Fetal time of de	uence of):  uence of):  uence of):  uence of):  uence of):	Ectopic p	and ive a	rterio		erotic	car	23d. Date Mor	e of delive	Onset and  lar di  any Day	year
Completed by Physician/Medical Examiner	s side of the control	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions.	23c. If y 1 4 5 9 5 5 cons contributions	Due to (or as a Due to (or a))))))))))))))))))))))))))))))))))))	a consequence of pregna 2 Fetal time of de	uence of):  uence of):  uence of):  uence of):  uence of):	Ectopic p	and ive a	rterio		23e. Did t	obacco Yes 2 an osy rimed?	23d. Date Mor	e of deliventh	ery Day ne cause of coably 4 psy findings mpletion of co	Year Unknown
Be Completed by Physician/Medical Examiner	s side of the control	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Jause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions.	23c. If y 1 4 5 9 5 5 cons contributions	Due to (or as a Due to (or as Due to (or as a Due to (or as a Due to (or as a Due to (or as a	a consequence of pregna 2 Petal time of de	uence of):  uence of):  uence of):  uence of):  uence of):  utleath 3 [  uency   death 5 [  utling in the uence of the uen	□Ectopic p □ Other (su	and ive a	erterio	f Death	23e. Did t 1 1 24a. Was auto auto aperic 100 Yes Check only (	obacco Yes 2 an obsy ormed? 2 \( \text{None} \)	23d. Date Mor	a of deliverable to the source of the source	ery Day Day Posy findings mpletion of c	Year Unknown
To Be Completed by Physician/Medical	r side coordinate of the coord	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \) Yes 2 \( \) No examiner?  25. Was case referred to medical examiner? 1 \( \) Yes 2 \( \) No 27. Manner of Death	b	Due to (or as:  Due to (or as:  Due to (or as:  yes, outcome  Live birth  Pregnant at  Unknown  ing to death bi	a consequence of pregna 2 Petal time of definition of the consequence	uence of):  uence	□Ectopic p □ Other (su	and ive a	en in Part I.  26. Place o	f Death	23e. Did t 1 1 24a. Was auto	obacco Yes 2 an obsy mmed? 2 \( \text{No} \text{No} \text{one} \) dence	23d. Date Mor	a of deliventh  abute to th  The prob  Were autoprifer to core th?  Yes  ar (Specify)	ery Day Day Posy findings mpletion of c	Year Unknowr
To Be Completed by Physician/Medical	r side coordinate of the coord	resulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	Due to (or as a Due to (or as Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due	a consequence of pregna 2 Petal time of definition of the consequence	uence of):  uence	□Ectopic p □ Other (su	oregnancy pecify)  cause give	en in Part I.  26. Place o	f Deathing Hom	23e. Did t 1 1 24a. Was auto perfor 100 Yes Check only ce e 5   Resi	obacco Yes 2 an obsy mmed? 2 \( \text{No} \text{No} \text{one} \) dence	23d. Date Mor	a of deliventh  abute to th  The prob  Were autoprifer to core th?  Yes  ar (Specify)	ery Day Day Posy findings mpletion of c	Year Unknown
To Be Completed by Physician/Medical Examiner	r side coordinate of the coord	Sequentially list conditions, any, leading to immediate ause. Enter Underlying auses (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	Due to (or as:  Due to (or as:  Due to (or as:  yes, outcome  Live birth  Pregnant at  Unknown  ing to death bi	a consequence of pregnative of pregna consequence of pregna consequence of pregna consequence of pregna consequence of pregna consequence of pregna consequence of pregna consequence of pregna consequence of pregna consequence of pregna consequence of pregna consequence of pregnative of pregna consequence of	uence of):  uence	□Ectopic p □ Other (su	oregnancy pecify)  cause give	on in Part I.	f Death ing Hom	23e. Did t 1 1 24a. Was auto perfor 100 Yes Check only ce e 5   Resi	obacco Yes 2 an obsy ormed? 2 No one) dence how inju	23d. Date Mor	e of deliventh  abute to th  Prob  Vere autorifor to core  th?  Yes  er (Specified	Onset and  lar di  any Day  ne cause of cably 4  psy findings mpletion of cably 2 \( \text{No} \)	Year Unknown available ause of
Certification; To Be Completed by Physician/Medical Examiner	side control of the c	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions are avaminer? 1 □ Yes 2 □ No  1 □ Natural 5 □ Pendin investig 3 □ Suicide 6 □ Couldr determ  29a. Certifier 1 □ Certifyin	b	Due to (or as a pue to (or as pue to (or as a pue to (or as a pue to (or as a pue to (or as a	a consequence of pregna 2 Fetal time of distance of the consequence of pregna 2 Fetal time of distance of the consequence of pregna 2 Fetal time of distance of the consequence of pregnance of the consequence of the consequ	uence of):  uence	□Ectopic p □ Other (su  Inderlying of  M  reet, factor	and ive a  oregnancy pecify)  cause give  OA Othe 28c. Injury Work 1 \( \) Ty, office	26. Place o	f Death ing Hom	23e. Did t  1 24a. Was autoperfor 150 Yes  Check only of e 5 Residd. Describe in the control of	obacco Yes 2 an obacco Yes 2 an obacco Yes 2 an obacco An obacco Yes 2 an obacco An ob	23d. Date Mor	e of deliventh  bute to th  The prob  Vere autorior to core et th? If yes  er (Specified  er or Rura	ery Day Day Posy findings mpletion of cause of the cause	Year  Jeath?  Unknown  available ause of
To Be Completed by Physician/Medical Examiner	P 2 2 2	Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	Due to (or as a pue to (or as))))))))))))))))))))))))))))))))))))	a consequence of pregna 2 Fetal time of distance of the consequence of pregna 2 Fetal time of distance of the consequence of pregna 2 Fetal time of distance of the consequence of pregnance of the consequence of the consequ	uence of):  uence	□Ectopic p □ Other (su underlying of  mt 3□ Do f M westigation	and ive a  oregnancy pecify)  cause give  OA Othe 28c. Injury Work 1 \( \) Ty, office	26. Place o	f Death ing Hom	23e. Did t  1 24a. Was autoperfor 150 Yes  Check only of e 5 Residd. Describe in the control of	obacco Yes 2 an osy 2 No one) dence how inju	23d. Date More use control of the More and Number (e)	e of deliverable of the state o	ery Day Day Posy findings mpletion of cause of the cause	Year  Jeath?  Unknown  available ause of
cation; To Be Completed by Physician/Medical Examiner	P 2 2 2 2 2	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Jause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  and II. Other significant conditions.  25. Was case referred to medical examiner? 1 ☒ Yes 2 □ No  27. Manner of Death 1 ☒ Natural 5 □ Pendin investig audical investig and determ  29a. Certifier (Check only one)  29b. Signature and title of certifier	23c. If y  23c. If y  1 L  4 L  9 L  ons contribution  Hospita  28a  19  19  19  19  19  28a  19  19  19  19  19  19  19  19  19  1	Due to (or as a pue to (or as))))). The pue to (or as a pue to (or as a pue to (or as a pue to	a consequence of pregna a consequence of pregnative of pregna a consequence of	uence of):  uence	Ectopic p Other (sy Inderlying of  M reet, factor th occurred th occurred	and ive a  pregnancy pecify)  cause give  OA Othe 28c. Injury Work 1 \( \) Ty, office	26. Place o	f Death ing Hom 28	23e. Did t  1 24a. Was autoperfor 150 Yes  Check only of e 5 Residd. Describe in the control of	obacco Yes 2 an Dosy Irmed? 2 No Done) dence how inju  Street aawn, State cause(s date an	23d. Date More use control of the More and Number (e)	a of deliverable to the state of the state o	onset and  lar di  ary Day  ne cause of the	Year  Jeath?  Unknown  available ause of
led in by the funeral director, page 2 should be detached for use as the but Certification: To Be Completed by Physician/Medical	P 2 2 2 2 3	Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	Due to (or as a pue to (or as))))). The pue to (or as a pue to (or as a pue to (or as a pue to	a consequence of pregna a consequence of pregnative of pregna a consequence of	uence of):  uence	Ectopic p Other (sy Inderfying of M reet, factor th occurred th occurred 29	and ive a  oregnancy pecify)  cause give  OA Other 28c. Injury Ty, office  d at the tim n, in my op oc. Licensee	26. Place of the property of t	f Death ing Hom	23e. Did t  1 24a. Was autoperfor 150 Yes  Check only of e 5 Residd. Describe in the control of	obacco Yes 2 an obsy ormed? 2 No one) dence how inju cause(s date an 29d. Da	23d. Date More use control of the large occurrence of the large occurrence of the large occurrence of the large occurrenc	e of deliverath  abute to the state of the s	onset and lar di	Year  Jeath?  Unknown  available ause of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28444 Certificate of Death 2, Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** :03 Andrew J. White AUGUST 5002 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil Union Hospital Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. June 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Director 071-48-8834 50 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23s or 28s-f show the Medical Evantinet must be notified at 1 Yes 2 No Be Completed by Funeral Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 614 Buttonwoods Road 21921 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 An Yes 2 □ No If Yes, Give Year or Dates: Marines Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene.
7 is marked other than 'traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew White Gloria McDermott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health :: If item 27 i 614 Buttonwoods Road, Elkton, MD Christina White/daughter other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☐ Burial 2 🕱 Cremation 3 🕅 Removal from State permit. Page Department of Important: if any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) <u>Fr</u>esh Pond Crematory | 08-15-2005 | Middle Village, NY 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee 111 S. Queen Street, Rising Sun, MD 21911 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or art failure. List only the cause on each line. Approximate Interval Between Onset and Death Immedial ause (Final disease condition resulting in death) **Physician** ENCEPINICOPATHY ANOXIC /Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILLAE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner ADLIT RESPIRATON DISTRESS SUDDOME physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): SERSIS Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE LIVEN DISCASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown LOAGNERATHY OF LIVEN DISCASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No DIAGETES MELLITUS 1 ☐ Yes 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident I Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Imp of certified 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

AUG 1 6 2005

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RODNEY DOWNING, D.D. DE BOW STREET O. a. Maying

32. Registrar's Signature

453419

ELKDY MD

AKUST 12.7.005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28445 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 19 2005° **Physician** 1425 DOROTHY C. WOOD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CAROLINE DENTON CAROLINE NURSING & REHAB CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye SEPT. 16 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sax 6 1913 **Funeral** 1□M 2X F MARYLAND 91 213-12-0272 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c City Town or Location 10a. State 10b. County or 28a-f show Examiner must be notified at Yes 2 No DENTON CAROLINE Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21629 USA 230 520 KERR AVE. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Items 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 XDivorced natural Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) then College (1-4or 5+) 5 Elementary/Secondary (0-12) PUBLIC EDUCATION TEACHER 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Importent: If item 27 is marked or any injury or other treumatic evenues. Pages 1 and 2 should be IPHIA KEMP LAURENCE CHERBONNIER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 612 DIAMOND ST., EASTON, MD 21601 J. MICHAEL STEWART/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY 8/23/2005 EASTON, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ostasusk 201-C. 580 0590% 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dua to for as a consequence off Examiner and any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physicien: The law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe ( 2 10 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural 28b. Time of After or Attending 5 Pending investigation after death.

I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Me of certifier pleted cause of death (Item 23a) (Type 30. Name and address of

DHMH 17 Rev 1/2001

State Registrar Jame

31. Date filed (Month, Day, Year) AUG 2 2 2005

**ORIGINAL** 

920

2. Registrar's Signature

		•	For State Registrar	State of Ma	aryland / Dep	artment of H		nd Mental I	Hygiene Reg. No	Zuub	28446
	Physici	an	1. Decedent's Name (First, Middle Richard Karl Wi					2. Date o Month 08 /			3. Time of Death 5:00 P <sub>M</sub>
7	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or	Location of			County of Death	
			Atlantic Gener			Berlin			W	orcester	
	Funeral Director		5. Social Security Number 188-42-1589	. D	e (In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month	f Birth , <i>Oay</i> , Year, <b>) / 1950</b>		place (State or Foreign ntry) nany
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Mary a-f sh	tor	MD Worce	ester	Berlin						1 ☐ Yes 2 XNo
	th the or 284 s not	Director	10e. Street and Number			10f. Zip Code			10g. Ci	itizen of What Cou	ntry?
	ath w	rali	88 Windjammer	T		21811		. 0.40		SA	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or ttems 23e or 28e-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Xtarri  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	Vo 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐Xo	spanic Orig in, Mexican, Specify:	In? (Specify Yes o Puerto Rican, etc.	)	14. Race - Ameri Black, White Specify: Wh	
Ö	2 hou	ted	15. Decedent (Specify only highes	's Education	16a. Dece	dent's Usual Occupa	ation	of working	16b. F	(ind of Business/Ir	ndustry
21215-0036	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+) life.	OO NOT use retired	()	or working			
	filed w Hygier sther th		12 17. Father's Name (First, Middle, I	3	Engi	neer	18 Mother	's Name (First, Mi			onstruction
anc		o Be	Karl Wittko	2431)				dalena Jo			
aryland	É DE E	၉	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Mail	ing Address (Street a				-	p Code)
≥	D # 17 #	1 8	Edith Wittko		88 W	indjammer	Roac	d. Berlin	. Mar	yland 2	1811
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Xremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Place of Disp	osition (Name of matory or other place nelopen		8/18/200!	20c. L	ocation - City or Tankford,	own, State
Balt	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service l	y. Past	erty 11	2. Name and Addres  O8 William:	s Stre	eet, Berl	in, M		ne 21811
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each li	the death. Do not en	ter the mode of dying	g, such as o	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
5	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Sepsi					,		
A.	/Medical Examiner			61	a consequence of):	2 1 4. 1	umu	-			
		Jer	Sequentially list conditions, if any, leading to immediate	b. Chonic Due to for as	ns once of):	of Cear	umu	· C			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	a Phenna	ni						
Ő,	e exe ian ar urial-t		resulting in death) Last	Due to (or as	a consequence of):						
8760,	cate b	dlca		d							
O. Box 6	ne death certificate be executed the attending physician and ched for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				23d. Date of deliv Month	rery Day Year
ds, P.0	w requires that the de been signed by the should be detached	by	Part II. Other significant condition	ins contributing to death b	ut not resulting in the	underlying cause give	en in Part I.				the cause of death?
Division of Vital Records,	@ S C	Completed							.: Was an autopsy performed? es 2 ☐ No	prior to co	opsy findings available ompletion of cause of
ita	iicien: Th certificate rector, pag	BeC	25. Was case referre medical examiner?				26. Place	of Death (Check o			
<b>)</b>	Physicien: r this certificatal director,	10 E	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie			4 🔲 1901	rsing Home 5 🗆 I			fy)
n c	ding Phys	lon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin		y Year) 28b. Time of Injury	Work	k?		ibe how inju	iry occurred	
isio	Attending ir death. ector: Affei by the fune	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be as Place of Ini	ury - At home, farm, st		Yes 2□N		on (Street a	nd Number or Rur	ral Route Number.
<u>&gt;</u>	or Attendate death	Certification;	4 Homicide determ	building, et	c. (Specify)	noot, lactory, office			r Town, Stat		
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C		g Physician. To the best Examiner: On the basis o and manner st	f examination and/or in						
	To th within To th compl	Me	29b. Signature and title of certified			29c. License	e number		29d. Da	ate signed (Month,	Day, Year)
			· ///	PARE		DS	3612	_	8/	15/05	
			Andrea K B	who completed cause of a	death (Item 23a) (Type 9733 H	29c. License DS Print) eathwa	ay le	or Broke	nine	0 2181	1
	Sta Regist		31. Date filed (Month, Day, Year)  AUG 1		rar's Signature	parti	0		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 28447 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 11, 2005 **Physician** 12: 30 M Annie Elizabeth Vass Young /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Feb. 15, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Year 1915 **Funeral** 1 □ M 2 🔀 F 90 Washington, DC 069-12-6095 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Modical Example, or native as fX Yes 2 No Silver Spring Maryland Montgomery Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with United States 3227 Bel Pre Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: African American ð 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Manager Public Schools of Health and Mental Hygintem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Howard Vass Ella Nora Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11404 Gilson Street, Silver Spring, MD Anna P. Grayson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of He
Importent: If iten
any injury or oth 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 8/19/05 Beltsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityMcGuire Funeral Service 21. Signature of Funeral Service Licensee 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. P. n. Enter the diserse, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast Mass **Physician** /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit certificate be executed Dementia Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) 4☐Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 \ Homicide i pellii To the Hospitei within 24 hours a To the Funerel C completely filled in 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D56691 August 15, 2005

Maryland 21215-0036

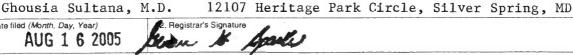
Baltimore,

Box 68760,

P.0.

Division of Vital Records,

31. Date filed (Month, Day, Year) State AUG 1 6 2005 Registrar



30. Name and at ress of person who completed cause of death (Item 23a) (Type, Print)

			for State Registrar	State of Man	yland / De <i>C</i>	partment of F ertificate of	lealth and l Death		giene <b>2</b> Reg. No.	2005	28448
Ì	Physici /Medic		1. Decedent's Name (First, Middle, Last,		AN	DERS		2. Date of De Month	P	2005	3. Time of Death 55 PM
- 12	Examin Funeral Director	ıęr	4a. Facility Name (If not institution, give:  GOOD SAMARITIAN  5. Social Security Number  365-64-0455	HOSPITAL	n yrs. last birthda 50 Yrs	BALT  If Under 1 Year  Months Days	IMORE If Under 24 Hrs. Hours Min.	8. Date of Bir	th y, Year)	Count	ece (State or Foreign try) H CAROLINA
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD. M/A	1	Oc. City, Town or						0d. Inside City Limits 1  Y Yes 2 □ No
	h with the 23a or 28a st be roti	al Director	10e. Street and Number 2800 CHISTOPHER	AVE.		10f. Zip Code 212	14			n of What Count	try?
920	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show he Medical Examinat must be routiled at	by Funeral		12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 1	3. Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)		Race - America Black, White, o	
Maryland 21215-003	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hyglene. itam 27 Is marked other than "natural" or itams 23a or 28a-1 show other traumatic avent, the Medical Examination must be redilised at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) -12-		(G life	cedent's Usual Occup ive kind of work done e. DO NOT use retire HOOL TEACH	during most of word  d)	rking	16b. Kind	of Business/Ind	lustry  TY SCHOOL
ıryland	2 should be filed vand Mental Hygie Is marked othar is aumatic avent, it	To Be (	17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Ty	UNKNOWN	19b. M	ailing Address (Street	RUTH A	ne (First, Middle, ANDERS ural Route Numbe			Code)
_	as 1 and 2 soft Health ar itam 27 ls		RUTH ANDERS (MOTH	IER)	10	72 BARLEN sposition (Name of crematory or other place	DR. RICH		2322		
Baltimore,	permit. Pages Department of I Important: If its any injury or o		1 □ Burial 2 □ Cremition 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature 1 F heral S MA Lens		OAKWOOD	CEMETERY Rame and Addre	8-29- ess of Facility BR		FUNER		EL
	Pnysician /Medical	1	23a. Part 1 Enter the disease, or compleshed, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	Metas	Hatie			or respiratory a			Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the conditi	onsequence of):	-					
P.O. Box 68	ne death certif the attending hed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 ( 4 Pregnant at tin 9 Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify)	у		230	d. Date of delive Month	ry Day Year
	w requires that the bear signed by should be detact	þ	Part II. Other significant conditions co	ntributing to death but I	not resulting in th	e underlying cause giv	ven in Part I.	23e. Did t		,	e cause of death? ably 4 \textcal{D}Unknown
Vital Records,		Completed						24a. Was auto perfo 1 \( \text{Yes} \)		24b. Were autop prior to con death? 1 \(\sum \text{Yes}\)	osy findings available inpletion of cause of
Division of Vita	nding Physician: The l tth. ". After this certificate ha e funeral director, page	atlon: To Be	25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2  Accident investigation	Hospital: 1 Impatient 28a. Date of Injury (Month, Day Y	2 ER/Outpa 28b. Tim Inju	e of 28c. Injury	ner: 4 □ Nursing H	ath (Check only of Home 5 Resi	dence 6 [		)
Divis	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		street, factory, office		28f. Location ( City or To		Vu <i>mber or Rurai</i>	Route Number,
	To tha Hospital within 24 hours To tha Funaral completely filled	Medical	29a. Certifier (Check only one)  1 【Certifying Phy 2 ☐ Medical Examination one)  29b. Signature and title of certifier	sician: To the best of einer: On the basis of einer and manner state	kamination and/o d.	r investigation, in my	opinion, death occu	urred at the time,	date and pl	ace, and due to	the cause(s)
)			Cuarles Piego	thu)	th (Itam 23a) (Tu	De Print! -	015546	- NF	ang	19,20	05
	Sta	ate	Charles Packa et  31. Date filed (Month, Day, Year)	equipoppleted cause of dea t aux 32. Registrices 1 2005	Signature	ech Rav	en Blo	Balt.	imov	e, MD	20239
	Regist	rar	AUG 3	I SAND > 35	AND NO	1					

State of Maryland / Department of Health and Mental Hygien 0 15

2	8	L	L	C
~	U	7	7	-

			1 - State Registrar		aryland /	Cer	tificate of	Death		Reg. No		28449
	Physici		1. Decedent's Name (First, Middle, L Angeline Yvette		ett				2. Date of De Month 08	ath 25	<sup>y</sup> 2005	3. Time of Death 05:30p M
	/Medio Examir		4a. Facility Name (If not institution, g Holy Cross Hosp	ive street and number			4b. City, Town, o	or Location of Death or Spring	00		County of Death Montgome	
	Funeral Director		268-66-4054	Sex 7. Ag 1 ☐ M 2 ☐ F	ge (In yrs. last b	rirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08-24			place (State or Foreign ntry)
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Lo	cation					10d. Inside City Limits
	Mary a-f sh	tor	MD Montgo	mery	Rock	vill	e					1 ☐ Yes 2 ☐ No
	th with the 23a or 28	ai Dire	10e. Street and Number 16113 Crabbs Wa	y #13	•		10f. Zip Code	20855			izen of What Cou JSA	ntry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. Its Medical Exam and must be recitified at Once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	?		Vas Decedent of H Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	-	14. Race - Ameri Black, White, Specify: Bla	etc.
15-0	"natur	ietec	15. Decedent's (Specify only highest of		168	a. Deced	ent's Usual Occup kind of work done	pation during most of work d)	ing	16b. K	ind of Business/In	ndustry
121	within iene. than	duo	Elementary/Secondary (0-12)	College (1-4or	5+)		ю мот use retire ial Work	-		N.	Non-profi	i +
	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, La				IGI WOLK	18. Mother's Nam	e (First, Middle,	i		
ylaı	ould b Menta	ToE	Henry Picque						e Roche			
, Maryland	and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship Marlene R. Buck		ther	167	81 Chagr	and Number or Run in Blvd.				
Baltimore,	Pages 1 ment of H ant: If Ited ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Special Content of the Content	□Removal from State			sition (Name of natory or other place ke Crema	I	Date 27-2005		eltsville	
Balt	permit. Departe Importe any inj		21. Signature of Funeral Service Lin	ensee	M0038Z	22. R 9	Name and Addre app Fune 33 Gist	ral & Cre Ave Silve	mation r Sprin	Serv	rice 20010	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	Progre	ne.	not ente	or the mode of dyin	ng, such as cardiac ukoenceph	or respiratory a	rrest,	20010	Approximate Interval Batween Onset and Death
	sit and	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	of):					-	
68760,	rificate be executed ng physician and as the burial-transit	cai Exam	that initiated events resulting in death) Last	cDue to (or as	a consequence	of):						
	rtificat ng phy as th	Medi	IE EEMALE.									
.O. Box	that the death cer ed by the attendir detached for use	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)	/			23d. Date of delive Month	ery Day Year
S, P	res that the igned by th be detache	by Pł	Part II. Other significant conditions	contributing to death t	out not resulting	in the un	derlying cause giv	en in Part I.	23e. Did to	obacco u	ise contribute to th	he cause of death?
ord	taw requires as been sign 2 should be	ted t	HIV Disease						101	∕es 23(	No 3 □ Prob	pably 4 □Unknown
Record	The ate h	Completed							24a. Was autop perfo 1 Yes		24b. Were auto prior to co death? 1 \sum Yes	ppsy findings available mpletion of cause of
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place of Deatl				-
of Vital	Phys r this ral di	L.	1 ☐ Yes 2 ☑ No 27. Manner of Death		ent 2 ER/O	utpatient Time of	3□ DOA Oth 28c. Injur	4 Li radi sirig i 10	me 5 Resid		6 Other (Specif	y)
Division	Attanding or death. ector: Altered by the fune	ation	1 XNatural 5 ☐ Pending investigate		y Year)	Injury	Wor	yat k? Yes 2 □ No	zod. Describe r	iow injur	y occurred	
DİXİ	in Qifte	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of In	ury - At home, f c. (Specify)	arm, stre	et, factory, office		28f. Location (S City or Tox	Street and vn, State	d Number or Rura )	al Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edicai	29a, Certifier 1 Certifying I (Check only one)	Physician: To the best aminer: On the basis of and manner st	t examination a	e, death	occurred at the tin estigation, in my o	ne, date and place, pinion, death occurr	and due to the e	cause(s) date and	and manner as si place, and due to	tated. the cause(s)
)	within 2 To the complet	M	29b. Signature and title of certifier  Volunt H	Lewis	MD		29c. Licens D005				e signed (Month,	
4	1		30. Name and address of person wh				nnt)		m 20010		, 20 2003	
	Sta	ite	Robert H; Geran	32 Registr	ar's Signature	n Kd	Silver	spring M	D 20910			
Di	Registi	- 1	AUG 3 1 2	32 Registr	es to	H						

			1 - For State Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death	Mental Hygie	C000 C0400
	Physic /Medi		1. Decedent's Name (First, Middle, Las AUTHOR I	th BARR		A06V)1	Day 26 2005 11:04 f M
	Examiı	ner	4a. Facility Name (If not institution, give NOPThWE	IST HOIPITAL		OWN	4c. County of Death  PAUTI MORE
	Funeral Director		072-32-0761	7. Age (In yrs. last birthday)  M 2XF  7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth Month, Day, Y	9. Birthplace (State or Foreign Country)
	anyland show	20	Usuat Residence of Decedent  10a. State 10b. County	10c. City Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 <b>1 1 1 1 1 1 1 1 1 1</b>
	vith the M or 28a-f	Funeral Director	10e. Street and Number	Nobb	10f. Zip Code	10g.	Citizen of What Country?
	r death v	uneral	719 Bellvieu	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	Decify Yes or No-	14. Race - American Indian, Black, White, etc.
9000	n 72 hours after death with the Marylar "naturef", or items 23e or 28a-f show odical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
1215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "naturef", or items 23e or 28a-1 show other treumatic event, Ite Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16b	b. Kind of Business/Industry
Ind 21	should be filed ward Mental Hygie marked other timatic event, IL	Be	17. Father's Name (First, Middle, Last)	Nur	18. Molher's Nam	e (First, Middle, Maid	eath Care
Maryland	2 should be filed and Mental Hygi is marked other eumatic event, I	2	Harold Lebb jea. Informant's Name/Relationship (7		Neg Address (Street and Number or Run	Barry Pal Route Number, Ci	ty or Town, State, Zip Code)
	es 1 and 2 of Health fitem 27 i		Andrea C. Oust 20a. Method of Disposition	20b. Place of Dispo	Siderdown G sition (Name of patory or other place)	Date, Date	Location - City or Town, State
Baltimore,	Pag nent ant: I		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	ruid k	Lidge 9/	2/05 4	!lesville, MD al Servicus
B	permit. Departr Importe any inju		Waughn C. K	Silications that caused the death. Do not entr	728 Liberty Rd.	Randells	town, md 21133
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCIERO		LVLAC -	Approximate Interval Between Onset and Death
ı	/Medical- Examiner		Sequentially list conditions	Due to (or as a consequence of):	9717.		
	acuted nd transit	Examiner	rany, reading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a consequence of).			
8760,	cate be executed physician and the burial-transit	dlcal Ex	resulting in death) Last	Due to (or as a consequence of): d			
Вох 68		n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □			23d. Date of delivery
0	that the deal	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown		Ectopic pregnancy Other (specify)		Month Day Year
rds, P	og og	ρχ	Part II. Other significant conditions co	ontributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Vital Records,	ne taw requir has been si ge 2 should	Completed			a*	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Vital	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examinar?	Hospital:		1 ☐ Yes 2 ☑ h Check on one)	
of	Phys	on; To	1  Ye's 2  No  27. May er of Death 1  Natural 5  Pending	1 ☐ Inpatient 2 ☐ ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		me 5 Residence 28d. Describe how in	6  ☐ Other (Specify) njury occurred
Division	ten leat tor: the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Street City or Town, Str	and Number or Rural Route Number, ate)
۵	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Phy	sician. To the best of my Inowledge, death	occurred at the time, date and place,	and due to the cause	Ve) and manner as stated
	To the H within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29d. [	Date signed (Month, Day, Year)
;		1	30. Name and address of person who c	ompleted cause of death (Item 23a) (Type, F	DY3481	A	NADYLIND 21133
4	Sta	to	MULAU R THICE  31. Date filed (Month, Day, Year)	W 5401 DUD COVE	FROAD RAMBAU.	Stown	MARYLIND 21133
	Registr		AUG 3 1	- And	GARAL .		,

			1 - State Registrar		nd / Depa	artment of Health an rtificate of Death	d Mental Hy	1 700	The Water of	201.5
			Decedent's Name (First, Middle, Last,	)		undate of Beatif	2. Date of De			3 Time of Death
	Physic		Raymond H. Blair				Month 08	Day 30 21	Peac 005	6 30 AM
}	/Medi Examii		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of D		4c. County		
			Riderwood Village	e Nursing Hom	ie	Silver Sprin	יפ	Mot	ntgome	orv
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs	. last birthday)	If Under 1 Year If Under 24		h		ace (State or Foreign ry)
	Director		306-14-0110	M 2□F 89	Yrs.	Months Days Hours	05-01	-1916		iana
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation			10	d. Inside City Limits
	/sho	ō	MD Montgon		ilver S				100	1 Tes 2 No
	28a-	ect	10e. Street and Number	mery 3	TIVEL	10f. Zip Code		10- 05		
	with Sa or	ā	3122 Gracefield F	Rd Apt 417		20904		10g. Citizen of W	nat Countr	ry /
	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or itema 23a or 28a-1 show of other than "natural", or itema 23a or 28a-1 show event, the Medical Examinational to incitified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in I	U.S. 13.		(Specify Yes or No		- America	n Indian
က	after of the state	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 No		Was Decedent of Hispanic Origin's f Yes, specify Cuban, Mexican, Po	uerto Rican, etc.)		k, White, et	tc.
8	ral', c	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No Specify:		Specify:	Whit	te
2-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occupation	working	16b. Kind of Bu	siness/Indu	ıstry
7	ithin ne.	np.	Elementary/Secondary (0-12)	College (1-4or 5+)	1	kind of work done during most of DO NOT use retired)				
2	filed with Hygiene. Ither than		17 Falbada Non - /First Middle / and	4+	Mech	anical Engineer		US Go		ent
Maryland 21215-0036	tal H	Be	17. Father's Name (First, Middle, Last) William O. Blair				Name (First, Middle,		<b>a</b> )	
⋛	should be filed within and Mental Hygiene. s marked other than umatic event, the M	2		0.00			Schauwec			
Ma	nd 2 sho lith and 27 is ma r trauma	9 1	19a. Informant's Name/Relationship (Ty William Blair/son			ig Address (Street and Number of $1$ Greencastle R				
<u>o</u>	1 ar Heal	100	20a. Method of Disposition		The same of the sa	sition (Name of	Date Dur LOII	20c. Location - (		
Baltimore,	00		1 ☐ Burial 2 📆 € remation 3 ☐ R	lemoval from State	cemetery, crer	natory or other place)				
≣	permit. Pag Department Important: I any injury o		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>			Name and Address of Facility	8-31-2005	Beltsv	тте	MD
Ba	Depi Impo		1000	H. M. (1)	15.13	Rapp Funeral &	Cremation	Service		
		-	23a. Part1. Exter the disease, or compli	ications that wused the dea	th. Do not ent	933 Gist Ave Si	lver Spri	ng MD 20		Approximate
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		001	_	1031,	1	nterval Between Onset and Death
	Medical		disease or condition resulting in death)	Man	Mu	7 The min	<del>}</del>			10 deep
	Examiner			Due to (or as a conse	quence or):	()	/			
		e	Sequentially list conditions,	Due to (or as a conse	quence of):				_	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o Î	en ar en ar rial-tr	EX	resulting in death) Last	Due to (or as a consec	quence of):					
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	cai		ı						
3	ntifica ng pt	Med	IF FEMALE:			_		I		
Rox	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			of delivery	
		sici	1 Yes 2 No	4 □ Pregnant at time of of 9 □ Unknown		Other (specify)		Moni	h Da	ay Year
л Э	that the ed by detach	Phy								
Š.	Se LE 90	by	Part II. Other significant conditions con	ithouting to death but not res	suiting in the ur	iderlying cause given in Part I.		bacco use contrib		
סבס	w require been sig should b	ted					- IIIY	es 2□No 3	1 X Propap	oly 4 Unknown
Vital Records,	elaw hasb je 2 sl	ompieted					24a. Was a autop:	sy pr	ere autops	y findings available detion of cause of
=	Pag ate	Co					perfor		eath? ]Yes 2[	□ No
	ysiclen: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:			Death (Check only or	10)		
0	hye this aldii	2	1 Yes 2 No	1 □ Inpatient 2 □		24	Home 5 Resid			
	ttending F death. :tor: After / the funer	ion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurre	d	
<u>.</u>	Attending r death. ector: After by the funer	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Place of laive. At h		M 1 Yes 2 No	00/ 1 10			
=	after Direction by	Certification	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	eet, factory, office	City or Town	treet and Number n, State)	or Rural R	Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Phys	ician: To the hest of my kno	nwledge death	occurred at the time, date and pla	and due to the o	auaa(a) and		
	24 h 24 h e Fur	edical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my opinion, death of	ccurred at the time, d	ate and place, an	id due to th	e cause(s)
:	To the within 2 To the comple	Me	29b. Signature and title of certifier	1/ //		29c. License number	2	9d. Date <b>≰</b> igned	(Month, Da	y, Year)
ľ			TRUL MON	Ut All		DUZZ-	15	8/20	105	
0	1/			mpleted cause of death (Iter				/ 00		
V						ver Spring MD 2	21234	/ /		
	Sta		31. Date filed (Month, Day, Year)	32. Pogistrar's Signa	atury 6	osale				
	Registr	ar	AUG 3 1 20	305 Mesur	~ 1%					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 28452 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MICHAEL JAMES BOOSE 12:25 AM 29 Aug. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ADVENTIST HOSPITAL SHADY GROVE Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1∑M 2□F (Month, Day, Year)
September 20, 1944 Washington D.C 220-40-5279 60 Director Usual Residence of Decedent Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Maryland Montgomery Gaithersburg 1 X Yes 2 No Director the 10g. Citizen of What Country? United States 10e. Street and Number 837 Kohinoor Court 10f. Zip Code 20878 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) during most of working permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than \*r any rijury or other traumatic event, the Med applica. Elementary/Secondary (0-12) 12 College (1-4or 5+) Painting Supervisor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph Franklin Boose Freda Mae Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon A. Boose / Wife 837 Kohinoor Court, Gaithersburg, Maryland 20878 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 31, 20c. Location · City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland Parklawn Memorial Park \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 21. Signature of Funeral Service Licensee M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG-CANGER NON- SMALL (EUL) IS MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Division of Vital 1 ☐ Yes 2**X** No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The destroying rhysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the I 29b. Signature and tyle of 29c. License number 29d. Date signed (Month, Day, Year) AUG. 29, 2005 D0061083

Registrar

2005 DHMH 17 Rev 1/2001

PAUL THAMBI

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9707

ORIGINAL

MEDICAL CENTER DR. #300, ROCKVILLE, MD

Eric Barnett 05-05717 RPD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

J) I	17		1 - For State Registrar	State of Maryland / Depa	artment of Health and N rtificate of Death		ene 2005	28453
	Dhysisi	-	1. Decedent's Name (First, Middle, Last)	11.		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Eric Bar	nett		August	24, 2005	1028 A M
	Examir	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death	
			607 Pennsylvania A 5. Social Security Number 6. Sex		Baltimore If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	MA	Jane (Chata as Fasaira
	Funeral Director			M 2 F 54 Yrs.	Months Days Hours Min.	Month, Day,	Year) Jour	place (State or Foreign htry)
			Usual Residence of Decedent			NOVIDA	1130 110	rylaria
	nylan how		10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	Ba-1-	Director	Maryland N/F	t Balt	imore			1 Yes 2 No
	in the	Dire	10e. Street and Number	11/2 1 1 404	10f. Zip Code	10	g. Citizen of What Cour	ntry?
	• 23e	erai	601 rennsy	Ivania Avei	$\perp \propto 1 \propto U/$	anit. Van as Na	14. Race - Americ	ladian
	Item Item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 Yes 2 XNo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
036	urs a	þ	3 ☐ Widowed 4 💆 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: P	ick
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-f ehow ta Maulcal Examiter must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. Dece	dent's Usual Occupation kind of work done during most of work	ina	6b. Kind of Business/In	dustry
21	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	T	2 11 4.1 1	1/1 + 1
	Hygier Hygier other ti		17. Father's Name (First, Middle, Last)	0 10	reman 18. Mother's Name	Circa Adiatalia A	Salto City I	Nater Dept.
Maryland	S in D S	Be	T	ne Barnett	R CO	+ o'. A O	1 C	0.5.
7	2 should I and Meni Ie marke aumatic	ို	James Bowe 19a. Informant's Name/Relationship (Type	De, Print) SIS et 19b. Mailir	ng Address (Street and Number or Run	al Route Number.	City or Town, State, Zio	Code
S	and 2 : Belth ar n 27 le		Mrs Valli Barn	ott Pryor 520	4 Elmer Ave	nue 7	Zatta Ma	51215
re,	es 1 and of Heelth fitem 27 r other tr		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	Date 2	20c. Location - City or To	own, State
E	Pages nent of int: If It iry or o		1 N Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	smovar from State	morial Park 9/1/	2005	Ralto 1	Nd.
Baltimore,	permit. Pag Depertment Important: I eny Injury o		21. Signature of Funeral Service License	ع ا	2. Name and Address of Facility	area 1	Hann DA	
<b>B</b>	99 E 2 A		Joseph &	KUSS 2	222 W. North Ave	Baite	Md.2121	صا
				ations that caused the death. Do not ent e cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	(the selection	Culi nos 4 C-	, Bre		Onset and Death
	/Medical Examiner		resulting an death)	Due to (or as a consequence of):				
	ŧ	9.	Sequentially list conditions, b	Due to (or as a consequence of).				
	uted d ansit	Examine	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
o,	exec en an rial-tr	Еха	resulting in death) Last	Due to (or as a consequence of):				
8760,	cate be executed physicien and the burial-transit	dical	d					
9	ing pt	Med	tF FEMALE:					
Вох	eath certifi attending     for use as	lan/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delive Month	ry Day Year
0	at the de by the a stached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)			
Ω.	£ 2 8		Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
Vital Records,	uires sign lid be	d by	casmic elco	heliam		1 ☐ Ye	s 2 No 3 Prob	ably 4 Unknown
2	w requ	jete				24a. Was an	24b. Were auto	psy findings available
Re	The lav	Completed				autopsy	ed? prior to con	npletion of cause of
ita		BeC	25. Was case referred to medical		26. Place of Deatl		No Yes	20 110
of <	S S D	To	examiner? 1 ⊈Yes 2 □ No	ospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing Ho	me 5 Resider	nce 6 <b>Z</b> Other ( <i>Specif</i> )	, At Scene
0		on:	27. Manner of Death 1 ANaturat 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe ho	w intury occurred	
sio	ten leath tor: the	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			1
Division	or Attend after death Director: ,	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	City or Town,	eet and Number or Rura State)	i Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Cartifying Phys	ician: To the best of my knowledge, death	n occurred at the time, date and place	and due to the ca	use(s) and manner as st	ated
	Ho.	edical	(Check only 2 Medical Examin one)	er: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, da	te and place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	4. 2/	29c. License number	29	d. Date signed (Month,	Dey, Year)
			The day	1. link	O.C.M.E.		August 25,	2005
1	1/2		30. Name and address of person who con	mpleted cause of seath (Item 23a) (Type,		3.5	1 1 01 001	
2	U		THE MORE MILE	ALCONOMICS CONTRACTOR	enn Street, Baltim	ore, Mar	yland 21201	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Begistrar's Signature	nade			
	region	-11	MUCI D I ZU	US RESERVED SU POS				

			State of Maryland / Department of Health and	•	•	
			1 - State Registrar Certificate of Death	R	eg. N2005	28454
	Physici /Medic	al	Frynk Dellen UN	2. Date of Dea Month		3. Time of Death A
	Examin	er	University of Maryland Baltimor		MA	
	Funeral Director		5. Social Security Number  6. Sex  7. Age [In yrs. last birthday] If Under 1 Year If Under 24 Hrs  Nonths Days Hours Min.		Year) Sout	place (State or Foreign
	iand ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		1,112,1190	10d. Inside City Limits
	ours after death with the Maryland el', or Items 23a or 28a-f show Examiner must be notified at	ctor	Maryland NA Baltimore			1 Yes 2 □ No
	with th	Funeral Director	106. Street and Number 21223	1	Og. Citizen of What Cou	ntry?
	tems 2	unera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
5-0036	72 hours after natural', or Ite dical Examine	þ	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give   1 ☐ Yes 2 ☑ No Specify:		Specify: Bl	ack
15-0	in 72 hours n "natural", redical Exe	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wolf iffe. DO NOT use retired)	rking	16b. Kind of Business/In	dustry
2121	filed within I Hygiene. othar than "	Com	Elementary/Secondary (0-12) College (1-4or 5+)  Laborer		Constru	action
land	ild be fi fental H rked otl lic evar	To Be		me (First, Middle, I	Flemin	a
Maryland	12 should be h and Menta 7 la marked fraumatic ev		19a. Inf	ural Route Number	r, City or Town, State, Zip	2 (2) 12
	nit. Pages 1 and 2 should be filed within 7: ortament of Health and Mental Hygiene. ortant: If item 27 Is marked othar than "n. injury or other traumatic evant, the Medl 8.		20a. Method of Disposition  20b. Place of Disposition (Name of competery, grematory or other glace)	1	20c. Location - City or To	own, State
Baltimore,	permit. Page Department of Important: If any injury or ance.		*4 Donation 5 Other (Specify) Mt, Carmel 9/3	12005	Dundalk	Md.
Ba	permi Depa Impo any ii		21. Signifure of Funeral Service Licente Russ Joseph L. Russ 2222 W. North Au	Funera 18. Balt	1 Home P.	A.
	2		23a. Pant. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)  a	0.5.3		1. 11
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	caecin	·MA	month
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			SYEARS
760,	te be executed ysician and ie burial-transii	icai E				
89 X	death certificate be e) e attending physician id for use as the buria	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	
.O. Box	0 0 C	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1		Month	Day Year
ords, P	w requires that the been signed by th should be detache	ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  EMP STAL RINAL AND ASE.	23e. Did tot	bacco use contribute to the	ne cause of death?
Vital Records,	The law ate has b page 2 sl	Completed by		24a. Was a autops perform	ned? prior to co	psy findings available mpletion of cause of 2 No
	Physician: Th this certificate ral director, pag	To Be	examiner?	ath <i>(Check only on</i> Home 5 □ Reside	e) ence 6 □Other (Specif	v)
on of	ling After fune				ow injury occurred	,,
Division of	or Attan Iter deat iractor: n by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or Rura 1, State)	l Route Number,
_	Hospital (	edical Ce	29a. Certifier  29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.)	e, and due to the ca	ause(s) and manner as s	tated.
	To tha h within 24 To the F complete	Medi	and manner stated.  29b. Siggature and title of certifier  29c. License number		9d. Date signed (Month,	
	N		poline P17677		August 20	2005
1	to the second		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	BAUTIM	ing Mn	21201
	Sta Registr		PULL OF LAND NAME OF CLASSICAL		,	

State of Maryland / Department of Health and Mental Hygien 20528455 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Patricia Crump 8 2005 /Medical 12:45a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3510 Ailsa Avenue BALTIMORE NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, ) 4-8-46 **Funeral**  Birthplace (State or Foreign Country) 1□ M 20 F Months Days Hours Min. 59 Yrs. Director 212-44-5484 Md. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show If e Medical Examinar must be notified at X□Yes 2□No Md. Baltimore NA **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3510 Ailsa Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married JYes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: γ Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ury or other traumatic event, Ire Ma Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Laborer Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Brooks 2 Cleo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephen Crump 3510 Ailsa Ave., Baltimore, Son Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. 9-2-05 Oaklawn Cem. Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 W aner March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ovangn Cancel disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760. IF FEMALE esn. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 2 🗹 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory of the filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier To the Hos within 24 hd To the Fund completely f Telegraphy Priyercian: 10 the basis of ray knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 8/30/05 DO053552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N-WOLFEST./PHAMS 281 BALTIALIE, MA 21287 E. BLBTOW, MA ROBERS Registrar's Signature State  $3^{r}1$ 2005 Registrar

		For State Registrar				d / Depa		t of H	ealth a			Reg. No.	711115	
Physiciar /Medica	1	Decedent's Name (First, M Vincent Vict									2. Date of Dea	25 <sup>Day</sup>	2005	3. Time of Death 09:57am
Examine	4a	. Facility Name (If not instite Brighton Gar					Che	vy C	Location of thase			ı	County of Deat	ery
Funeral Director		Social Security Number 004-16-3026 sual Residence of Deceden		M 2□F	7. Age (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birtl (Month, Da) 11-25-		. 1	hplace (State or Foreigr untry) Maine
Maryland -f show	10	a. State 10b. Cou		ery		y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with the 23a or 28e	10	be. Street and Number 5555 Friends	hip B	lvd			10f. Zip	Code	2081	.5		10g. Citiz	en of What Co	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event. Its Medical Examinating the multiput any once.	11 nd rullel	. Marital Status  1 □ Never Married 2 1 □ Nev	Married	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	2 No		Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	1	4. Race - Ame Black, White Specify White	e, etc.
Vidity Identity A. I. A. 13-0030 12 should be filed within 72 hours aft h and Mental Hygiene. 7 is marked other than "natural", or raumatic event. Its Medical Exprin TO Be Completed by E		(Specify only his Elementary/Secondary (0-1	2)		-4or 5+)	_	dent's Usua kind of wo DO NOT us nimis	rk doné d se retired	luring mosi )			Co		ng Company
Mall y latter  of 2 should be file  lith and Mental Hy  27 is marked oth  traumatic event	17	Arthur Checcl				_					(First, Middle, 'isani	Maiden :	Sumame)	
is 1 and 2 shu of Health and item 27 is m other traum		9a. Informant's Name/Relati Vincent A. Cl la. Method of Disposition	necch	i/son			Mass	Ave	NW W	ashi	Route Number ngton Date	C 20		
partification of permit. Pages 1 at Department of Hea Important: If item any injury or otha once.	2	1 ☐ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe 1. Signature of Funeral Sen		20	C C	hesape	aké C 2. Name an	rema	tory	y	26-2005		Beltsv:	ille MD
permi Depar Impo any ir	2	3a. Part1. Enter the disease	Hime o, or compli	ann	MOO382 aused the deat						mation r Sprin		rice 20910	Approximate
Physician and // / / / / / / / / / / / / / / / / /	d	shock, or heart failure. mmediate Cause (Final isease or condition sulting in death)  equentially list conditions, any, leading to inmisulate ause. Enter Underlying ause (Disease or injury at initiated events		Due to (	osdysp or as a conseq	uence of):	Synd	rome						Interval Between Onset and Death
		sulting in death) Last		Due to (	or as a conseq	uence of):	- <del>,</del>							
that the death certificated by the attending pridetached for use as it	2	3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	2	1 Live b	come of pregna irth 2  Feta ant at time of d own	Ideath 3[	Ectopic pr Other (sp					2	3d. Date of deli Month	very Day Year
quires that an signed I utid be det	֓֞֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	at II. Other significant con Hypertension	ditions cor	tributing to de	eath but not res	ulting in the u	nderlying c	ause give	n in Part I.					the cause of death?  obably 4 □Unknown
		Conjestive He Atrial Fibri			<u> </u>						24a. Was a autops perform	sy	24b. Were au prior to death?	topsy findings available completion of cause of 2 No
ding Phys	2	5. Was case referred to med examiner? 1	H	28a. Date o	npatient 2 of Injury h, Day Year)	ER/Outpatier 28b. Time o Injury		8c. Injury Work	or: 4x Nu	rsing Hon	(Check only or ne 5 Residence Reside	ence 6		ify)
tal or Attending P rs atter death. al Diractor: Atter ted in by the funers		3 ☐ Suicide 6 ☐ Co	uld not be emined	28e. Place buildir	of Injury - At hong, etc. (Specif	ome, farm, str y)	eet, factory	, office		2	28f. Location (S. City or Town	treet and n, State)	Number or Ru	ral Route Number,
To the Hospital or Attentivities 24 hours after deall to the Funeral Diractor: completely filled in by the		9a. Certifier 1 💢 Certifier (Check only one)	fying Phys cal Examir	sicien: To the ner: On the ba and mann	asis of examina	wledge, deat tion and/or in	n occurred vestigation,	at the tim	e, date an	d place, a	and due to the c	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)
To the within To the comp		9b. Signature and title of cer	_/	Li	100	lu	-	DC5			2		signed (Month 26-2005	
50			an 202	21 K St	Ste 4	04 Was	hingt		C NW	200	06			
State Registrar	•	1. Date filed (Month, Day, Y	3 1 21	105 32. R	gistrar's Signa	ture	bode	,						

	1 - For State Registrar	State of Ma		partment of I		Re	eg. No.200	5 2845
Physician /Medical Examiner	Jeanne D. Cat	lett		4b. City, Town, o	or Location of Deal	2. Date of Deat Month 08	Day Yes 25 2005 4c. County of D	08:15p
Funeral Director	Holy Cross Host  5. Social Security Number  058-14-2941  Usual Residence of Decedent		(In yrs. last birthda 96 Yrs.		r Spring If Under 24 Hrs Hours Min		Montgo Year) 9.1 1909 N	omery Birthplace (State or Foreig Country) Iebraska
with the Maryland so 28a-1 show be notified at	MD 10a. State 10b. Count Mon	gomery	10c. City, Town or Silver	Spring				10d. Inside City Limit tXXYes 2 ☐ N
or Items 23s	8505 Springva.  11. Marital Status  1 Never Married 2 Ma	12. Was Decedent E Armed Forces? 1 \( \text{Yes} \) 2 \( \text{Yes} \)	ver in U.S. 13	10f. Zip Code  3. Was Decedent of H Yes, specify Cub  1 ☐ Yes ঽ□X\o			0g. Citizen of What  USA  14. Race - A Black, W  Specify: E	merican Indian, hite, etc.
ygiene. ne then "naturel", c nt, me Modical Exter	3√√√Vidowed 4 □ Divorce  15. Decede (Specify only high  Elementary/Secondary (0-12)	d Year or Dates:  nt's Education  set grade completed)  College (1-4or 5+	16a. Dec	edent's Usual Occur ve kind of work done DO NOT use retire	pation	rking	16b. Kind of Busine	
	17. Father's Name (First, Middle	4+ , Last)	·	t <u>Teacher</u>		me (First, Middle, Maheth Rob	,	on
if Health and Menitem 27 is marke other treumatic	19a. Informant's Name/Relation Robert Catlett	ship (Type, Print)	8	iling Address (Street 710 Geren	and Number or R	ver Sprin	City or Town, State	0
Department of Hoportent: If item sny injury or oth snce.	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (  21. Signature of Funeral Service	Specify)	Chesap	position (Name of ematory or other pla eake Crema 22. Name and Addre	atory 08		20c. Location - City Beltsvi	
eny sany	23a. Part 1. Enter the disease,	oliman	he death. Do not e	Rapp Fur	neral & (		ng MD 209	Approximate Interval Between
hysician /Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	ratory For consequence of):	ailure				Onset and Death
/sicia	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Chlos	consequence of):	Diffrcile	Toxin Er	iteritis		
C L =	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at to 9 ☐ Unknown	Fetal death	B⊟Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
engi-	2 Part II. Other significant conditi	ions contributing to death bu	t not resulting in the	underlying cause gr	ven in Part I.			to the cause of death?  Probably 451 Unknow
ate has	Completed					24a. Was as autops perform 1 Yes	y prior	autopsy findings availab to completion of cause of ?? 'es 2 \to No
sid P	O 1 ☐ Yes 2 ☐ No	Hospital: 1 ☑ Inpatier  28a. Date of Injury (Month, Day)		of 28c. Inju	ner: 4 🗆 Nursing I	28d. Describe ho	nce 6 ⊡Other (S w injury occurred	
ours after death. serel Director: Attent filled in by the funeral		building, etc.	(Specify)	street, factory, office	me date and size	City or Town	, State)	Rural Route Number,
within 24 hours after To the Funeral Direct completely filled in by		ing Physician: To the best of I Exeminer: On the basis of and manner state	examination and/or	investigation, in my o	opinion, death occ	urred at the time, da	ate and place, and of the and place, and of the signed (Motor 1988)	onth, Dey, Year)
XX	30. Name and address of perso	nwho completed cause of de Sie 1111 Sprir	ath (Item 23a) (Typ	e, Print)	- MD 200	10		

State of Maryland / Department of Health and Mental Hygiene For State Registra 28458 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Benjamin Franklin Dean, III 27, August 2005 12:07 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4977 Battery Lane, #619 Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 200-22-4330 November 22, 1927 Minnesota Director 77 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r then "natural", or items 23s or 28s-1 show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4977 Battery Lane, #619 20814 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Korean 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify δ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Manager Insurance Company filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any linury or other traumatic event page. Be Benjamin Franklin Dean, Jr. Adele Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Alan Dean / Brother 1 Southerly Court, Unit 405, Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) August 29, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2005 Bethesda, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility.
Obert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Un M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy ō Day Year 4□Pregnant at time of death ned by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an hes autopsy performed? 1 ☐ Yes 2 🖾 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely tilled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Nother (Specify) Hospital: 2 1 X Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🛚 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 T Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51916 atricia August 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike, G-100, Rockville, Maryland 20852 Patricia Tomsko Nay, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year 10:30 PM<sup>M</sup> /Medical George S. Davis, Jr. August 29, 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Brighton Gardens Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1XIM 2□ F Yrs. Director 561-54-3742 Michigan October 14, 1920 Usual Residence of Decedent 10a State id 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
27 ie marked other than "natural", or Itame 23a or 28e-1 ehow traumatic event, the Medical Examiner must be notified at 10h Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 6114 Wilson Lane Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes, 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Commander United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George S. Davis, Sr. Flora North 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 s ment of Health an Itam 27 i Deborah Davis Kelsey/ Daughter 6114 Wilson Lane Bethesda, Maryland 20817 20b. Place of Disposition (Name of commetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. August 4 □ Donation 5 □ Other (Specify) 30, 2005 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Fineral Service Licensee 23a. Part1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cete hes been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimer's Disease 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificete 1 ☐ Yes Hospital or Attending Physicien: : After this certifical funeral director, p Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death. To the Hospital or Attendi within 24 hours efter death. • To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) filled in by 28f. Location (Street and Number or Rural Roule Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to lhe cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D26259 August 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ava A. Kaufman, M.D. 8218 Wisconsin Avenue #103 Bethesda, Maryland 20814-3501 31. Date filed (Month, Day, Year) 32. Signature State AUG 3 1 2005 Registrar & specker

DHMH 17 Rev 1/2001

**ORIGINAL** 

		1 - For State Registrar	State of	Maryland	/ Depa	artment rtificate	of He	alth a eath	nd Me	ental Hy	giene 2	005	284	6
	sician edical	1. Decedent's Name (First, Midd Flora F.	e, Last) Gross							2. Date of Dea Month .ugust	Day 22	Year 2005	3. Time of De 7:30p	
Exa	miner	4a. Facility Name (If not institution 308 Brightwood	d Club Driv	re		4b. City, To	rvil	lle			В	nty of Death		
Funer Direct		5. Social Security Number  109-16-3542  Usuel Residence of Decedent	6. Sex 7 1 ☐ M 2 🔀 F	Age (In yrs. lasi	Yrs.	If Under 1 Months		Hours	Min.	8. Date of Birt (Month, Day JUN 12	1922	9. Birthpl Count	ace (State or Fo	oreign
Maryland	Į į	10a. State 10b. County	imore	10c. City, T		cation Ville						10	d. Inside City L	
ath with the Marylar 23a or 28a-f ehow	Funeral Director	10e. Street and Number 308 Brightwood	d Club Driv	re .		10f. Zip C	210	93			10g. Citizen o	of What Count	ry?	
filed within 72 hours efter death with the Maryland Hygiene. Hydrehen "netural", or fteme 23s or 28s-f ehow ent, the Madical Examiner must be notified a	by Fune	3 ☐ Widowed 4 ☐ Divorced	If Vac Give	es? X No	1	Was Deceder f Yes, specify		anic Origi Mexican, Specify:	in? (Spec Puerto R	cify Yes or No- lican, etc.)	14. R B	ace - America lack, White, e	tc.	
within 72 hours of sne. then "netural", or the National Starm	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)		(Give life. l	lent's Usual ( kind of work DO NOT use	Occupation done duri retired)	on ing most o	of workin	g		Business/Ind	-	
o la b	To Be Co	17. Father's Name (First, Middle,	Last) Kelstein		HOme	maker	18	8. Mother Sula		(First, Middle,	Maiden Sum	wn Home	2	
C = '4 F	3 1	19a. Informant's Name/Relations Gerald Gross -			308 B	rightw	700d		Dri	Route Number				3
Page lent o nt: If ry or		20a. Method of Disposition  1 Burial 2 Cremation 4 Donation 5 Other (S	pecify)		apeake		ory I			2005	Belts	o · City or Tov		
permit. Depertm Importa	ouc	23a. Part1. Enter the disease, o	ue Relter	MO144	3 CĀ	FA, St 17'Gre	ephe en F	n D. Pastu	Loh res	rmann, Drive,	PA Towson		21286 Approximate	
ate be executed // Medic Examine physicien and physicien and the burial-transit	al er ច	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last	Due to (or b	h	ica of):	~			-				Interval Betwee Onset and Deat	
death certific e attending p d for use as	ian/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 □ Fetel de it at time of death	ath 3	Ectopic pregi Other (speci						Pate of delivery Month E	y Day Year	
law requires that the di as been signed by the 2 should be detached	۵	Part II. Other significant conditi		th but not resultin	ng in the ur	derlying caus	se given i	in Part I.					cause of death	
The la ate hes page 2	Q.	2000								24a. Was a autops perform	sv	. Were autops prior to com death? 1 \( \text{Yes} \) 2	sy findings avai pletion of cause	lable of
Physician: The riths certificate he ral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	atient 2 ER	/Outpatien	3□ DOA				Check only on		ther (Specify)		
ding After fune	o.	27. Mann of Death  Natural 5 Pendir  Accident investi	gation	Injury 28 Day Year)	b. Time of Injury	28c.	Injury at Work?	s 2 □ No	28	d. Describe h	ow injury occu	ırred		
	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place of building	Injury - At home , etc. <i>(Specify)</i>						City or Town	n, State)		Route Number,	
o the Hoepital vithin 24 hours in the Funeral ompletely filled	Medicai	one)	g Physician: To the basi Examiner: On the basi and manner	s of examination	dge, death and/or inv	occurred at t estigation, in	he time, o my opinio	date and pon, death	place, an occurred	at the time, d	ate and place	, and due to t	he cause(s)	
To With	7	(-)	newwo					704			8-2	ed (Month, Di 13-0 S		
00	State	30. Name and address of person  MARY M. NS WMA  31. Date filed (Month, Day, Year)	V, M. Q. 10	155 FAL	LSK			00	4	UTH SA	evill	E M	01093	
	State istrar	AL	G 3 1 2005	Gere	d	Specie	le le							
					ORIGII	VAC								

			1 _ For	State of N		d / Depa		Health and	Mental Hygi	•	28461
			1. Decedent's Name (First, Middle,	/ act)		Cei	illicate of	Dealii	2. Date of Death		
	Physici	ian	1. Decedent's Name (First, Middle,	,					Month	Day Year	3. Time of Death
	/Medi Examir	cal	4a. Facility Name (If not institution,	Arla Jea give street and numbe		olig	4b. City, Town, o	or Location of Dea		26, 2005 4c. County of Death	11:20 AM <sup>M</sup>
		•	Montgomery H					Rockville			gomery
	Funeral		5. Social Security Number 6	.Sex 7 1 □ M 2 💢 F	Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. Birth	place (State or Foreign intry)
	Director		214-32-9367 Usual Residence of Decedent	TO IM ZOU.	82	Yrs.			March 13	, 1923 Wash	ington,D.C.
	land		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Many f sh	Į.	Maryland Mon	taamaru			Cor	ithersbu	ca	-	1 ☐ Yes 2X No
	the 288	rec	10e. Street and Number	tgomery		-	10f. Zip Code	TUILETSDU		g. Citizen of What Cou	intry?
	3a ol	ā	16212 Orc	hard View	Court			20878		United	Statos
	ms 2	nera	11. Marital Status	12. Was Deceder	nt Ever in U.S	3. 13.	Vas Decedent of I		Specify Yes or No- to Rican, etc.)	14. Race - Ameri	can Indian,
9	after or its	F	1 Never Married 2 Married				l Tes, specity Cub I⊡ Yes 2]XD No		to Rican, etc.)	Black, White	, etc.
003	ural',	d b	3 N Widowed 4 □ Divorced	Year or Date:	s:					Specify:	White
Maryland 21215-0036	within 72 hours after death with the Maryland sne. than "neturel", or itams 23a or 28a-f show in Medical Eraninar marke ricilited at	Completed by Funeral Director	15. Decedent's (Specify only highest			16a. Deced	lent's Usual Occup kind of work done	pation during most of wo d)	orking 1	6b. Kind of Business/Ir	ndustry
12	withly lene. than	Ę.	Elementary/Secondary (0-12) 12	College (1-4d	or 5+)	me. t				IImdon IIoo	J
d 2	filed Hygie ther		17. Father's Name (First, Middle, La	st)			Kece	ptionist 18. Mother's Na	me (First, Middle, M		dquarters
an	d be ental cad o	o Be		ames D. Yo	ahum					ne Hillman	
Ž	2 should I and Men is marka	L C	19a. Informant's Name/Relationship		CHum	19b. Mailir	a Address (Street	l and Number or R		City or Town, State, Zi,	
M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Executer must be rediffed at any injury or other traumatic event, the Medical Executer must be rediffed at anothing.		John J. Grolig,	TV/ Son						hersburg,M	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra <u>once</u> .		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other pla	ce)		0c. Location - City or T	
Ë	Pages nent of h int: If its iry or of		1 X Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe		10		lemorial I	Park 20	gust 2005	Rockville,	Maruland
alti	mit. partm sorta / inju		21. Signature of Funeral Service Lic		Lair	22	. Name and Addre	ess of Facility Ro	bert A. F	umphrey Fu	neral Home/ Avenue
m	Depa Impo eny ir	1	1 Change T	Kusha	M003	35	Rockvil	le, Inc. le, Marv	300 West Land 20850	Montgomery 0-2805	Avenue
			23a. Part1. Enter the disease, shock, or heart failure. List or	m flications that causely one cause on each							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		cemia						Onset and Death
	/Medical		resulting in death)	- W	as a conseque	ence of):					
	Examiner		Sequentially list conditions.				Extremit	у			
	pg is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·	as a conseque	•					
	and and I-trans	Examiner	that initiated events resulting in death) Last		ced Di		Mellitu	ıs			
760,	ate be executed hysician and he burial-transit	caiE		240 10 (6)	23 4 001130401	31,00 31).					
687	phys phys s the	edic		d							
ox (	certil nding use a	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						23d. Date of deliv	erv
ă	death a atter	iciai	in the past 12 months? 1 □ Yes 2 🛣 No		2 Fetal of time of dea		Ectopic pregnancy Other (specify)	y		Month	Day Year
0	t the coy the archer	Physician/M	9 Unknown	9□ Unknown							
٥,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as it	by P	Part II. Other significant conditions	s contributing to death	but not resul	lting in the ur	iderlying cause giv	en in Part I.	23e. Did toba	icco use contribute to t	he cause of death?
rd	w require been sig should b								1 ☐ Yes	2 <b>X</b> No 3□ Prol	pably 4 Unknown
Records,	e law re has be ge 2 sho	Completed							24a. Was an autopsy	24b. Were auto	ppsy findings available empletion of cause of
		Son							perform	ed? death? XINo 1 ☐ Yes	
Vital	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?						ath (Check only one		
of \	ys dis	P	1 ☐ Yes 2 💢 No		itient 2 E		1 3□ DOA Oth	1er: 4 ☐ Nursing I		ce 6 MOther (Specia	y Hospice
		lon;	27. Manner of Death 1 X Natural 5 ☐ Pending		gury Day Year)	28b. Time of Injury	28c. Injur Wor	rk?	28d. Describe how	injury occurred	
Sign	Attending r death. sctor: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could no	be one Blace of	niun. At hon	no form et-	M 1 ==	Yes 2 □No	29f Location (Stre	et and Number or Rura	of Davis Mumber
Division	after Direct	Certification;	4 Homicide determine	building,	etc. (Specify)	ne, iaini, sin	et, lactory, office		City or Town,		ar noble Number,
	Hospite 24 hours Funerel etely filled	S S	29a. Certifier 1 Certifying	Physician: To the be	st of my know	rledge, death	occurred at the tir	me, date and place	a, and due to the cau	ise(s) and manner as s	tated
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	ledical	(Check only 2 Medical Ex	aminer: On the basis and manner	of examination	on and/or inv	estigation, in my o	pinion, death occi	urred at the time, dat	ise(s) and manner as s e and place, and due to	the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	201/	)		29c. Licens	e number	290	d. Date signed (Month,	Day, Year)
) ,			CLERK	IL	_		0	1421	8	8126	105
C	ノン		30. Name and address of person wh	o completed cause of	f death (Item :	23а) (Туре,	Print)	72 <del>5</del> -772		0,100	
_(	)		Charles Hsrrison				Mill Ro	ad Rockv	ille, Mary	land 20855	
	Sta	-	31. Date filed (Month, Day, Year)	107	strar's Signatu 	ILE T					
	Registi	iell .	AUG 3 1 2	LUUD / Ille	10 D	S. S.					

		State of Maryland / Department of Health and 26 per Verb., G846, 08/31/05dbb ath  1. Deggdent's Name (First, Middle, Last)	Reg	2005 2846 3. Time of Death
Physic /Medi		Peter Hansmann	AUGUST	-26 2005 0227 N
Examir		4a. Facility Name (If not institution, give street and number)  Nov thwest Hospital Randalstor	non	4c. County of Death Bal H Marve
Funeral Director		5. Social Security Number 6. Sex 1		9. Birthplace (State or Foreig Country) Md
Maryland	tor	10a. State   10b. County   10c. City, Town or Location   Sykesville		10d. Inside City Limit:
ith the	Oirec	10e. Street and Number 10f. Zip Code	100	. Citizen of What Country?
s 23e	ral	6655 Sykesville Road 21784		USA
hours after death with the Maryland turet; or Items 23e or 28a-f show al Examiner must be notilied at	by Funeral Director	11. Marital Status  1. Was Decedent Ever in U.S. A med Forces?  1. Where Married 2 Married 3 Widowed 4 □ Divorced  1. Was Decedent Ever in U.S. A med Forces?  1. □ Yes 2. □ No If Yes, Give Λ Year or Dates:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
72	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of w	orking 16	bb. Kind of Business/Industry
e filed within al Hygiene. other than '		unknown never worked  17. Father's Name (First, Middle, Last) 18. Mother's N	ame (First, Middle, Ma	uiden Sumame)
Mental Arked o	To Be	unknown unkr		
S D E E		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Information (St		
1 and 2 should be filed within 72 hours afteath and Mental Hygiene. 77 is marked other than "naturel", or ther traumatic svent, the Modical Exami		Springfield Hosp. Med. Records 6655 Sykesville Rd.,  20a. Method of Disposition (Name of	76	e, Md 21784 Oc. Location - City or Town, State
permit. Pages 1 a Department of Hez mportant: If Item iny injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	C <sub>1</sub>	kesville, Md
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once.		ppringitera dem. 102	laight Fune	eral Home & Chapel
Medical Examiner bhysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last  Due to (or as a consequence of):  b.  Due to (or as a consequence of):  c.  Due to (or as a consequence of):  d.		
requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of delivery Month Day Year
w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ <del>Un</del> know
The law ate has b page 2 sl	Completed		24a. Was an autopsy performa	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
	To Be	examiner?	eath (Check only one) Home 5 - Resident	ce 6 Oction (Specify)
Jing After fune	Certification: T	27. Manner of Death  1. Ratural 5   Pending investigation 3   Suicide 6   Could not be 28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M 1   Yes 2   No 28b. Time of Injury At home farm street factory office	28d. Describe how	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		4 Homicide determined building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plan	City or Town,	State)
To the Hos within 24 ho To the Fun completely i	Medicai	(Check only one)  Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time, date	and place, and due to the cause(s)
To To	2	29b. Signature and title of certifier  29c. License number  D 00368	riting a state	1. Date signed (Month, Day, Year) 4 Ugust 26, 200  MN 21/33
	(	30 Name and address of person who competed cause of death (Item 23a) (Type:Print)  540 0 2 Road Randwill  31. Date filed (Month, Day, Year)  32. Registrar's Signature	stown	mp 21/33
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 3 1 2005  32. Registrar's Signature		

State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrar 28463 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1120 Bobby E. Hill 27 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical Center University Bultmore NA 6. Sek 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12-14-30 9. Birthplace (State or Foreign Country) West Va. **Funeral** Days Months Hours Min 1 X M 2 □ F 74 Yrs. Director 232-44-7401 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or Iteme 23s or 28e-f ehow Examiner must be notified at 1 Yes 2 No Directo Clinton Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6403 Symposium Way 20735 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3 ∠Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Federal Mine Inspecter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be fil ment of Health and Mental H ant: If item 27 is marked otl jury or other traumatic even Ellsworth Hill Easter Vanatter Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Hill 6403 Symposium Way, Clinton, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department important: I eny injury o Hill Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Leet, W. Va. 9-2-05 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave. & and wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CERTIFIE ON APPROVED BY MEDICAL EXAMINES **Physician** Respiratory railure /Medical Due to (or as a consequence of): Examiner Quadrap legia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner physician and s the burial-transit Physicien: The law requires that the death certificate be executed Fall Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical SE 950 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page certificate 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury A M or Attending 1 Natural 5 Pending 1 ☐ Yes 2 No death. 7/21/05 Fall 2 Accident investigation Director 6 Could not be determined Suicide □ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Home clinton within 24 hours a To the Funarel ( 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of sertifie 29d. Date signed (Month, Day, Year) 16540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Greene Street Bulto. MD I. Tawi 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar AUG 3 1 2005

46 pS cm, Eavl 8/30/05 10:10 Ат. Ваltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

,,	P. 2 2 1 11 0 -0 3 10 10 1	
State of Maryland / Department of Health and Menta	al Hygien <b>e2 () () 5</b>	28
Certificate of Death	Reg No	

	-	For State Registrar		State o	t Mar	yland /		artment of H <i>rtificate of l</i>		and M	ental Hy			5	28464	
* W. &		Decedent's Nam	ne (First, Middle, L	ast)				timouto or i	Jean		2. Date of D	Reg. No eath	). 		3. Time of Death	_
Physiciar /Medica	-	Earl			I	Hopso	n				Augus	st 3	$0, 2^{4}$	0 0 5	10:10AM	
Examine		4a. Facility Name (	If not institution, gi	ve street and nu		<del>-</del> 7		4b. City, Town, or	Location o	of Death		4c	. County of	Death		
``		Gilchri						Towso					Balt			
Funeral		5. Social Security N		Sex 11∕2∏ M 2 □ F	7. Age (i	In yrs. last bi 62	rthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of B (Month, D	irth ay, Year)	9	. Birthpl Coun	ace (State or Foreign try)	
Director	-	217-40-1 Usuaf Residence o				02					May 1	1,, 1	943Bi	ılad	ean, NC	_
with the Maryland a or 28a-f show tencilite an		10a. State	10b. County		1	Oc. City, Tov	vn or Lo	cation						10	Od. Inside City Limits	
a Ma		MD	Baltim	ore		Dunc	dalk								1 ☐ Yes 2 🙀 No	
vith the		10e. Street and Nu						10f. Zip Code				10g. Cit	tizen of Wh	at Coun	try?	
a 23a		1126 Ste	elton Av	12. Was Dec	odont Eur	or in II C	13.1	21222		-i=2 /C	-4V N		USA 14. Race -	A	- ladia	_
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itema 23s or 28s-f show event, Ira Modical Examinar most be notified at Completed by Funeral Director.			ried 2 <b>X</b> Married 4 □ Divorced	Armed Fo	rces? 2 ₩ No ve	91 111 0.3.		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2∏ No	Specify:	gin? (Spe i, Puerto f	Rican, etc.)	0-		White, e	atc.	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural;, any injury or other traumatic event, Ita Modical Exa 2006.			15. Decedent's E	ade completed)	4.45.	16a	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most	t of workir	ng	16b. K	ind of Busin	ness/Ind	ustry	
d with giene		6 years	ondary (0-12)	College (	1-40r 5+)		La	borer					onstr	uct	ion	
be file tal Hyg d othe		17. Father's Name	(First, Middle, Las	t)					18. Mothe	r's Name	(First, Middle					_
Ments Ments arked arice		Carrick	Hopson			,			Hetti	ie Fr	ancis					
12 sh and reum		19a. Informant's N	· ·					g Address (Street a							Code)	
1 and Health arn 2 ther t	-	Arthur H		broth				ampler Ro	bau, i		liore,		ocation - Ci		wn State	_
Pages ment of ant: if it iury or o		1X Burial 2	☐ Cremation 3 5 ☐ Other (Spec		State	cemete	ry, cren	natory or other place t of Jesus		epte 2, 20			dalk,		vii, State	
permit Depart Import any in		21. Signature of Fu	uneral Service Lice	insee	n	all.	22 C 7	Name and Address onnelly 1 110 Solle	s of Facility unera ers Po	al Ho	me Of Road,	Dund	lalk,P lalk,	.A. Md.	21222	
10 11 11 11		23a. Part1. Enter t shock, or hea	the diseas, or con art failure. Ly t only	nplications that of	aused the	e death.		er the mode of dyin					0.3590		Approximate Interval Between	1
Physician		Immediate Cause disease or condition	(Final	a	L	UNE		LANCER						1	Onset and Death	
/Medical Examiner	1	resulting in death)	1	Due to	(or as a c	onsequence	of):									
sit sit		Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	onditions, mmediate artying	b. Due to	(or as a c	onsequence	of):									_
be executed cien and purial-transit		that initiated events resulting in death)	s	cDue to	orasa c	onsequence	of):							+		_
ficate be physicie as the bur			•	d										1		_
ath certific ttending p or use as		IF FEMALE:		23c. If yes, out	come of a	Dreananay										_
requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the burial-transisted by Physician/Medical Examilated by Physician/Medical Examilated		23b. Was deceden in the past 12 1 Yes 2 9 Unknown	! months? □ No	1 Live b	ointh 2 (	Fetal death		Ectopic pregnancy Other (specify)	-				23d. Date o Month		y Day Year	
quires that in signed k uld be deti		Part ff. Other signif	ficant conditions				in the ur	ndertying cause give	en in Part I.		1	tobacco u Yes 2			a cause of death?	
hes to											24a. Was auto perfo		prio	r to com th?	sy findings available apletion of cause of	
certiticate   rector, pag		25. Was case refer examiner?	rred to medical						26. Place	of Death	(Check only			103		
arthis eral di		1 Yes 2 2 2 27. Manner of Deat 1 Naturaf 2 Accident		28a. Date (Mon			utpatient Time of fnjury	28c. Injury Work	at Nur	2	ne 5 ☐ Res 8d. Describe		6 Other (	Specify	Hospice	_
tal or Attending P s after death. al Director: Attert ed in by the funera Certification:		3 Suicide 4 Homicide	6 Could not I determined	28e. Pface	of Injury ng, etc. (	- At home, fa Specify)	arm, stre	eat, factory, office		2	8f. Location ( City or To			or Rural	Route Number,	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atte completely tilled in by the fun Medical Certification		29a. Certifier (Check only one)	1⊠ Certifying P 2 ☐ Medical Exa	hysician: To the miner: On the band man	asis of ex	amination ar	e, death	occurred at the time restigation, in my op	e, date and pinion, deat	d place, a h occurre	nd due to the	cause(s)	and manne d place, and	er as sta	ited. the cause(s)	-
To the comp		29b. Signature and	title of certifier	1	0	, -	$\wedge$	29c. License	number			29d. Dat	te signed (A	Aonth, D	ay, Year)	-
2	1	14	Mithe	my the	Ky	L' Cy	<u> </u>	リン	5 20	ل		Hu	9057	30	2,2005	
		30. Name and addr	ress of person who	completed caus	of deal	h (Item 23a)	(Type, I	Print) Charles	St	Pice	lto.n	nd 2	2(20	×	Pay, Year)	
State Registrar			AUG 3 1 2	005	egistrar's	Signature	do	usi)								

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month STING **Physician** 2 -12:40 PM AUGUST 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 M 200 214-22-3351 Yrs. October 9, PA. **Director** 83 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow any civity or other traumatic event, the Medical Examilier must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 XNo Dundalk Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 3409 Louth Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed by 3 

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theresa Dorchinz Frank Ozohomish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3409 Louth Road, Dundalk, MD. 21222 Gary Villani Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 30, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2005 Dundalk, MD. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. any r 21222 7110 Sollers Point Road, Dundalk, MD. 23a. Part. Enter the disease or emplications that caused the death. Or not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of **Examiner** OVARIAN CANCER METASTAT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑No φ Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 3 DOA Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) filled in by the funeral Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurrad at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month. Dev. Year) 29b. Signature and title of certifier 29c. Licensa number D 24334 owers 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMORE, MD 4940 31. Date filed (Month, Day, Year) 32. Megistrar's Signature State AUG 3 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene  $2\,0\,0\,5$ 28466 1 - State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** <u>3:4</u>5P <sup>™</sup> AUGUST <u>ETHEL I. HAY</u> 24 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Cockeysville 6. Sex 7. Age (In yrs. last birthday) Baltimore Cockeysville Catered Living If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 New York **Funeral** 8. Date of Birth (Month, Day, Year) 1 M XX F Yrs. Director 94 219~28~9063 Aug. 24,1911 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28a-f show other treumstic event, the Medical Examinar must be notified at Baltimore Towsor 1 Yes 2X No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 E. Joppa Rd. Unit 505 21204 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3€XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "r. any injury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Insurance Business 12 yrs. 17. Father's Name (First, Middle, Last) N/A 18. Mother's Name (First, Middle, Maiden Sumame) John Steven Brennan Adelaide Burnham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8376 Tanu Court Baltimore, Md. 21236 <u>Greg Hay</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 8~27~05 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home assakov Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a co burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the S IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 € No 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death Check onle one Hospital: Other: 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE SUITE 101 7401 OSLER 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of M	1arylar	nd / Depa	artme <i>rtifica</i>	nt of H	lealth a	and N	lental Hy	gier Reg. 1	2005	28	3467
	Physici	an	1. Decedent's Name (First, Middle, La	st)							2. Date of De	ath	Dav Year	3. Time	e of Death
	/Medi			h P. Hal		ier					August	29	, 2005	7:	11 A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, giv		r)				Location of	of Death			4c. County of Deal		
			7907 Sleaford Pl 5. Social Security Number 6. S		on /In ure	last birthday)		theso	ia If Under	24 Hrs	0. Data of Bir		Montgome		
	Funeral Director			_M 20∏F	74	Yrs.	Months		Hours	Min.	(Month, Da	25. Yea	9. Bin Co 1930 Mass	nplace (Stal luntry) SAC h11 S	etts
			Usual Residence of Decedent				1	l			TOVCHIDEL		, 1550		
	nylan how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation								City Limits
	Ba-f	ct	Maryland Montgom	ery		Bet	hesd	a						1 U Y	es 2. No
	vith th	Funeral Director	10e. Street and Number				10f. Z	p Code					Citizen of What Co		
	s 23s	a l	7907 Sleaford Pl		4 E. H. W	10 110			0814				ited Sta		
	Item de	n n	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Deceder Armed Forces 1 ☐ Yes 2 🕅	?	J.S. 13.	If Yes, sp	edent of H	ispanic Ori in, Mexicar	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	0^	14. Race - Ame Black, Whit		,
336	urs af	5	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 Tes	2X No	Specify:				Specify: Wh	ite	
21215-0036	within 72 hours after deeth with the Maryland ene. then "natural", or items 23s or 28s-f ehow fre Madical Exeminar must be notified at	Completed	15. Decedent's E			16a. Dece	dent's Usi	al Occup	ation	4 =4		16b.	Kind of Business	Industry	
21	thin 7	ng.	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4o	r 5+)				during mos ()	t of work	ing				
2	ed wi	ပ်		4		Hom	nemak	er				1	wn Home		
gu	12 should be filed within "h and Mental Hygiene." 7 le marked other then "fraumatic event, the Mes	Be	17. Father's Name (First, Middle, Last,								e (First, Middle		en Sumame)		
ž	hould d Mer nark natic	2	Raymond F. Power  19a. Informant's Name/Relationship (			10h Maili		- /Ct			ine Lyn		y or Town, State, 2	F- 0- (-)	
Maryland	s 1 end 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, Ira Medical Examinar must be notified at		Roger B. Halbardi		and		-						laryland	, ,	
	1 end Health tem 27 other ti		20a. Method of Disposition	- 11480		Place of Dispo			1	- 1	Date		Location - City or		
ΘĽ	Peges nent of int: If it		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		0	cemetery, crei Lgomery			1	Augus 200	st 31,		thesda,		
Baltimore,			21. Signature of Funeral Service-Licer		1	-			- 1						
ä	permit. Depertr Imports eny inj		21. Signature of Funeral Service Licensee  M01305  22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy C 7557 Wisconsin Avenue, Bethesda, Maryland 20814-										Chase, 4-3501	Inc.	
			23a. Part1. Bater the disease, or com shock, or heart failure. List only	plications that cause	ed the deat	th. Do not en	ter the ma	de of dyin	g, such as	cardiac	or respiratory a	rrest,	,	Approxin	nate
4	Physician		Immediate Cause (Final disease or condition			Neck C	ance	r						Onset an	nd Death
	/Medical		resulting in death)	Due to (or a										0 1101	
	Examiner	L	Sequentially list conditions,	b											
	ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consec	quence of):									
	and and al-tran	хап	that initiated events resulting in death) Last	c Due to (or a	s a consec	quence o!):									
8760,	law requires that the death certificate be executed es been signed by the attending physicien and 2 should be deteched for use as the burial-transit	Physician/Medical Examiner	· ·	d											
89	ificate g phy as the	ed		d.											
Вох	death certifica attending ph	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Tetopia						23d. Date of del	very	
-	deat ed for	sicia	in the past 12 months? 1 ☐ Yes 2 🌠 No	4☐Pregnant			∐Ect <i>o</i> pic p ☐ Other (s						Month	Day	Year
P.0	thet the death ted by the atter	Phys	9 Unknown					<del></del>							
	res the iigned be del	Ď	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.				ouse contribute to		
of Vital Records,	w requir been s should	Completed									1 1	Yes	2 No 3 Pr	obably 4	
Sec.	e law hes b	ig .									24a. Was auto	psy	24b. Were au	topsy linding completion o	gs available if cause of
alF	t age										1 Yes	med?	death? No 1 ☐ Yes	2 □ No	
V.	Phyelcien: Th this certificete ral director, per	Be	25. Was case referred to medical examiner?	Hospital:				OA Othe	20		(Check only o				
	Physic refrisher	. To	1 ☐ Yes 2 🔯 No  27. Manner of Death	1 🗀 Inpai		ER/Outpatier		07	4 🗆 🕅		me 5 🔀 Resi	-	6 ☐Other (Specially occurred	cify)	
on	Attending Ph r death. ector: Atter th by the funeral	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	м	28c. Injury Work	<br Yes 2 □ I				jury coodinod		
Division	Attendir death.	Ifica	3 Suicide 6 Could not be determined	28e. Place of la	njury - At h	ome, larm, str	reet, facto	y, office			28f. Location (	Street	and Number or Ru	ral Route N	um <i>b</i> er,
ā	s efter al Direct	Certification:	4   Homeda	building, e	itc. (Specif	<b>(y</b> )					City or To	wn, Sta	ite)		
	To the Hospitel or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	edical (	29a. Certifier  (Check only 2 Medical Exam	ysician: To the bes	t of my kno	owledge, deat	h occurred	at the tim	ne, date an	d place,	and due to the	cause(	(s) and manner as	stated.	0/6)
	To the He within 24 To the Fu	Medi	37.07	and manner s	stated.					occuri	at 1118 IIII18,				
	T V VIII	<	29b. Signature and title of certifier	l'a	-		29	c. License					ate signed (Montl		)
	1	2	1 Garage	) (41)				D004	41119			Aug	ust 30,	2005	
4	4		30. Name and address of person who Daya S. Sharma, N					ad.	Silve	r Sn	ring. M	(art	land 209	10	
	Sta	te	31. Date filed (Month Page 737) 1	32. <b>P</b> is	trar's Signa	ature				_ <u> </u>					
	Registr		HUG 3 1 2	(005	leen .	H A	Signal .	7000							

	<i>.</i>		1- For Amend Item Registrer	23a State of M	larvland / Dep .,G846,08/	artment of 105dhb rtificate of	Health a f <i>Death</i>	nd Mental Hy	giene Reg. No. 2 (	005	281	468
	Physici	an	1. Decedent's Name (First, Middle,	_			-	2. Date of De Month	ath Day	Year	3. Time of E	Death
	/Medie			OHNSON		17		08.06	2005		8:10	Рм
	Examir	ner	4a. Facility Name (If not institution,	give street and number, SPITAL	)	4b. City, Town, SILVER	SPRINE		4c. County		0050	
	Funeral				ge (In yrs. last birthday)	If Under 1 Yea	r If Under 2	4 Hrs. 8. Date of Bir	PRINCE	9. Birthpla	RGES ce (State or	Foreign
	Director		220 · LA · 7717 Usual Residence of Decedent	1∭M 2□F	49 Yrs.	Months Days	s Hours	Min. (Month, Da 09.27.	955	Country	MD	
	ryland thow		10a. State 10b. County	1	10c. City, Town or Lo	_				100	l. Inside City	
	ith the Marylar or 28e-f show	cto		IA	BALTIMORI						1. SYes 2	2 [ No
	with the or 2	Funeral Director	10e. Street and Number 3310 EDGERTON	ROAD		10f. Zip Code			10g. Citizen of V	What Country	y?	
	death wi	nera	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		<del>-</del>	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac	e - American		
9	after dea or Items	Fur	1 ☐ Never Married 2 ☐ Marrie	Armed Forces d 1 ØYes 2 ☐ If Yes, Give	No	If Yes, specify Cu 1 ☐ Yes 2 2 No		Puerto Rican, etc.)		k, White, et	C.	
93	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show salical Examirer must be notified at	d by	3 ☐ Widowed 4 ( Divorced	Year or Dates:					Specify	BLACE		
215-0036	in 72 n "nat	olete	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occu kind of work don DO NOT use retir	upation e during most ed)	of working	16b. Kind of Bu	ısiness/Indu	stry	
212	d within giene. ar than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) EN	GINEER			TRANSPO	RIATIO	M	
nd	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Itam 27 Is marked other then "natural", or Items 23e or 28e-1 show other traumetic svent, the Modical Exertirer rust be notified at	Be	17. Father's Name (First, Middle, L	ast)			11.5	's Name (First, Middle	, Maiden Sumam	ie)		
Maryland	should Ind Men	<sup>2</sup>	ALBERT JOHNSON	(Table Grief)	401.14.11		GERAI					
Mai	nd 2 sho alth and 27 Is m		19a. Informant's Name/Relationsh MARIUN JOHNS					or Rural Route Number			ode) 21117	
<u>6</u>	s 1 and 2 f Health Itam 27 othar tra		20a. Method of Disposition	3010	20b. Place of Dispo cemetery, cre	osition (Name of	IILL CIR	Date Date	20c. Location -			
E	Pages nent of int: If it		1 ☐ Burial 2 🗹 Cremation 1 ☐ Donation 5 ☐ Other (Sp		GREEN MC	_		8.15.05	BALTIMO	QF. A	ΔD	
Baltimore,	permit. Pages 1 a Department of Hez Importent: If itam any injury or otha once.		21. Signature of Funeral Service L	censee \	The state of the s			FUNERAL SE		100 1		
m	205 20		Vaughn	(4-	51	51 BALTO.	NATU PI	KE, BALTO. 1	ND 21229			
			23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final	nly one cause on each	line.	ter the mode of dy Cirrhos	-	ardiac or respiratory a	rrest,	l Ir	pproximate iterval Betwe inset and De	een
	Physician /Medical		disease or condition resulting in death)	a. Dua to for a								
	Examiner				s a consequence of): IAC FAILUG	E						
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):							-
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.		FAILURE						
8760,	ate be executed hysician and the burial-transit		rooding in doutily suot	Due to (or as	s a consequence of):							
687	flicate physis the	edic		d								
Вох	feath certifica attending ph for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		JEctopic pregnan	CV.		23d. Dat	e of delivery		
Ю. В	The law requires that the death certificate be executed te has been signed by the attending physician and tage is should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Other (specify)			Mor	nth Da	ay Ye	ar
<u>α</u>	that the de led by the a detached i		Part II. Other significant condition	s contributing to death I	but not resulting in the u	nderlying cause o	iven in Part I.	23e. Did to	obacco use contr	ibute to the	cause of dea	ath?
ecords,	quires tha n signed I ıld be det	d by						10	Yes 2 ₺No	3 Probab	ly 4 ∐Un	iknown
000	aw requir is been s 2 should	Completed						24a. Was	an 24b. V	Vere autops	y findings av	/ailable
$\alpha$		Com						autop perfo 1 ☐ Yes	rmed? d	rior to comp leath? Yes 2	letion of cau □ No	ISB Of
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	I Managhari				of Death (Check only o				
of	this al di	- T	1 Yes 2 No	Hospital: 1 ☐ Inpati 28a. Date of Inji		IL 3 DOA		sing Home 5 Resid	dence 6 Othe			
O	Attending Product death. actor: After by the funeral	tlon	1 Matural 5 Pending 2 Accident investiga	(Month, Da	ay Year) Injury	W	ork? ∐Yes 2∐N		low injury occurr	<b>6</b> 0		
Division	or Attendi after death. Diractor: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be 28e. Place of In	ijury - At home, farm, sti	reet, factory, office	9		Street and Number	er or Rural R	oute Numbe	9 <i>r</i> ,
Ö	tel or A rs after al Dira ed in by	Cert	4 - Horricos	building, e	tc. (Specify)			City or Tov	vn, State)			
	To tha Hospitel or At within 24 hours after or To tha Funaral Dirac completely filled in by	edical	29a. Certifier 1 Certifying (Check only one) Medicel E	Physician: To the best caminer: On the basis of and manner st	of examination and/or in	h occurred at the t vestigation, in my	time, date and opinion, death	place, and due to the noccurred at the time,	cause(s) and mai date and place, a	nner as state and due to th	ed. le cause(s)	
	To the To the Comp	Me	29b. Gignature de title of certifier	1 /1		29c. Licen	ise number	201	29d. Date signed	(Month, Da	y, Year)	
			20011	WVV		D	) T	734	0-7	-03		
			30. Name and address of person w	LK, 1221	death (Item 23a) (Type, MECHAN rar's Signature	Print) ILE LN	. LAF	2GO MD	20774			
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		1					
	Registr	ar	AUG 3 1 2005	District M	- Island							

/Medio	an cal	Decedent's Name (First, Middle, Last     Sara		er phy G849		_	nson		2. Date of De Month	Day	Year 2005	3. Time of 53	of Death
xamir		4a. Facility Name (If not institution, give J.H.H. Bayvie		)	4b. City, T		Location o		<del></del>	4c. Co	unty of Death		
neral ector		214-40-7298	7. A	ge (In yrs. last birthday) 65 Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 10-7-	h y Ye <i>ar)</i> 39	9. Birth Cou	place (State intry) N .	or Foreigr
Fed at	tor	Usual Residence of Decedent  10a. State 10b. County  M.d. N.A		10c. City, Town or Lo	ocation altimor	re						10d. Inside C	City Limits
at be not	Funeral Director	10e. Street and Number 3649 Chesterfield	Ave.		10f. Zip (		1213			10g. Citizer	of What Cou		
Examinar no	ğ	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 2 If Yes, Give Year or Dates:	No	Was Decede If Yes, specif 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)		Race - Ameri Black, White pecify: B		
in nem zz is markeo other than 'natural, or nema zas or zsa-r show or other traumatic event, the Mudical Examinar must be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation de completed) College (1-4or	5+) (Give	dent's Usual kind of work DO NOT use m Pro	k doné di e retired) OCESS	uring most			Dept	of Business/Ir t. of I ulation	Labor	ic.
natic even	To Be	17. Father's Name (First, Middle, Last)  John	н.	Bridge			Eli	za	(First, Middle,	. C	ozart		
om 27 is nother traum		19a. Informant's Name/Relationship (T) Albert M. Johns		Husband	364	19 CI			d Ave	-			212
Important: if iter eny injury or oth once.		20a. Method of Disposition  1 □  ↑ a □ Donation 5 □ Other (Specify)		20b. Place of Dispo cemetery, crea King Me	matory or oth	her place	)	9-3-	-05		tion - City or T lallstow		ā.
eny inj once.		21. Signature of Funeral Service Licens	~ Wo	22	2. Name and Marc					nore,	Md. 2 North	1202 Ave.	
ician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that cause ne cause on each	d the death. Do not en	ter the mode	of dying	, such as o	cardiac o	r respiratory at	rest,		Approxima	to.
dical		disease or condition resulting in death)	d		espir a	tory	1	oilu	, e			Interval Be Onset and	tween
dical nine prinal-transit	dicai Examiner	disease or condition	b. Due to (or as Due to (or as Chron	s a consequence of):					, Dise	<b>45</b> 6		Onset and	tween
dical dical	nysician/Medicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a:  Due to (or a:  C.  Due to (or a:  Due to (or a:  Due to for a:  Due to for a:	s a consequence of):  s a consequence of):  s a consequence of):  s a consequence of):  of pregnancy  2   Fetal death   3		egnancy					I. Date of deliving Month	Onset and	tween
or the attending provided on a constant and ached for use as the burial-transit	by Physician/Me	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or a:  Due to (or a:  C. Chro.  Due to (or a:  d	s a consequence of):  s a consequence of):  c O6517  s a consequence of):  e of pregnancy 2 Fetal death at time of death 5	□Ectopic pre	egnancy pointy)	Pulmo		Dise	23d	Month	Onset and	Year
page 2 should be detached for use as the burial-transit	Physician/Me	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a:  Due to (or a:  C. Chro.  Due to (or a:  d	s a consequence of):  s a consequence of):  c O6517  s a consequence of):  e of pregnancy 2 Fetal death at time of death 5	□Ectopic pre	egnancy pointy)	Pulmo		23e. Did to 185	23d	Month  contribute to t	ery Day the cause of 6	Year Unknow
S certificate rias been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	o Be Completed by Physician/Me	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions co	Due to (or a:  Paeur  Due to (or a:  Chro  Due to (or a:  1 Live birth 4 Pregnant a 9 Unknown	s a consequence of):  s a consequence of):  s a consequence of):  s a consequence of):  e of pregnancy 2	□Ectopic pre- □ Other (spe-	ognancy ocify)	n in Part I.	of Death	23e. Did to 1 S  24a. Was autor XX Yes (Check only of	23d  bbacco use  fes 2 \( \text{N} \)  an 2  sy sy sy sy sy sy sy sy sy sy sy sy sy	Month  contribute to to the second of the se	ery Day  he cause of chably 4   popsy findings impletion of company in the cause of cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company i	tween Death  Year  Unknow
Arter trits certificate rias been signed by the attending physician and triansit and tuneral director, page 2 should be detached for use as the burial-transit and the contract of the contrac	To Be Completed by Physician/Me	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or an PARUM)  Due to (or an Due to (	s a consequence of): s a consequence of): s a consequence of): s a consequence of): s a consequence of): s a consequence of): s a consequence of): but not resulting in the unit of death of the sequence of t	Ectopic predother (special of the second of	ognancy cify)  use given  A Other Sc. Injury Work	n in Part I.	of Death	23e. Did to 1 🗷 🔾	23d  bbacco use  fes 2 \( \text{N} \)  an  sy med 2  7 ne)	Month  contribute to to the second se	ery Day  he cause of chably 4   popsy findings impletion of company in the cause of cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company in the cause of company i	Year Unknow
tor. After this certificate has been signed by the attending physician and in the funeral director, page 2 should be detached for use as the burial-transit and in the funeral director.	Certification; To Be Completed by Physician/Me	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as Du	s a consequence of): s a consequence of): s a consequence of): s a consequence of): s a consequence of): s a consequence of): s a consequence of): but not resulting in the unit of death of the sequence of t	□Ectopic pre □ Other (special of the second	egnancy ecify)  iuse givel  3c. Injury Work' 1 🗆 Y	n in Part I.	of Death sing Hom	23e. Did to 18 24a. Was autop perfo	23d  bbacco use  fes 2 \( \text{N} \)  an  sy med  lence 6 \( \text{Lence} \)  sow injury of	Month  contribute to to the second se	ery Day  he cause of chably 4 Deposy findings impletion of control of the control of the control of the cause	Year  Year  Unknow  availaba  availaba  ause of
Futieral precont. Ariet files certificate rias been signed by the attending physicial end in pipelitansit in pipelitied in by the funeral director, page 2 should be detached for use as the burial-transit in pipelities.	Certification; To Be Completed by Physician/Me	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or an PARUAL  Due to (or an Due to (	s a consequence of):  s a consequence of):	DEctopic prediction of the control o	egnancy perify)  Luse givel  Bc. Injury Work'  1  Y	n in Part I.  26. Place  4 \( \text{Nur} \)  at  7 es 2 \( \text{Nu} \)	of Death sing Home	23e. Did to 1 25  24a. Was autor perio XX yes (Check only one 5 Reside 8d. Describe 16) 8f. Location (5) City or Tow	23d  bbacco use  fes 2 N  an  ssy med  photo  ne)  lence 6 N  sow injury of  cause(s) and	Month  contribute to to the state of the sta	ery Day  the cause of obably 4   psy findings  impletion of of   XXNo	Year  death?  Unknow  available cause of
in by the funeral director, page 2 should be detached for use as the burial-transit up to the funeral director.	To Be Completed by Physician/Me	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or and the property of	s a consequence of):  s a consequence of):	Ectopic predother (special of the special ancy perify)  Luse givel  Bc. Injury Work'  1  Y	n in Part I.  26. Place  1. 4 Nur  at  27.  es 2 N	of Death sing Home	23e. Did to 125.  24a. Was autop perfo XX yes (Check only one 5 Resides 8d. Describe had at the time, and the time	pbacco use  Yes 2 No  an 2  Syrmed?  The control of the control of	Month  contribute to to the state of the sta	ery Day  the cause of the cause	Year  Year  Unknow availab ause of	

			For State of Ma	aryland / Depa <i>Cei</i>	artment of Health ar rtificate of Death	nd Mental Hy	/giene2 005 28470
			1. Decedent's Name (First, Middle, Last)			2. Date of D	eath 3. Time of Death
	Physicia /Medic		Robert Earl Jennings			August	26 2005 4:10 A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of I	Death	4c. County of Death
			6527 Gravel Branch Road		Hurlock	Um I a minute	Dorchester
	Funeral Director		218-32-0961 <sup>1</sup> ∑M 2□F	71 Yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Bi (Month, D Aug 26	av. Year) Country)
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mary -f sho	į	aryland Dorchester	Hurlock			1 ☐ Yes 2 🖾 No
	r 28a	Directo	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
	th wit		6527 Gravel Branch R.		21643		United States
	r dea	Funeral	11. Marital Status 12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "naturel", or Items 23a or 28a-f show ery injury or other treumatic event. The Madical Examination at the Intelligible and ORGE.	by	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 ☐ MNo Specify:		Specify: Whtie
2	72 hc	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most o	f working	16b. Kind of Business/Industry
2121	within ane. then	Completed	Elementary/Secondary (0-12) College (1-4or 5	+)	DO NOT use retired)		Carpenter
d 2	filed Hygie other ent.	ပိ	12th 17. Father's Name (First, Middle, Last)	Millw		Name (First, Middle	e, Maiden Sumame)
Maryland	lid be ked c ked c ic eve	To Be	Robert Moreland Jennings		Sus	an Morgan	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir			per, City or Town, State, Zip Code)
	and 2 saith a n 27 i		Ly Jennings (Wife)		Gravel Branch R		k, MD 21643
ore	ges 1 I of He If iten		20a. Method of Disposition 1 ☎ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place)	Date	20c. Location - City or Town, State
altimore,	t. Pag rtmen rtant: njury	1	'4 □ Donation 5 □ Other (Specify)		v Memorial Park	8/29, 200	5 Sykesville, MD
Ba	Departiment of the policy of the policy in the policy in the policy in the policy of t		21. Signature of Funeral Service Licensee		2. Name and Address of Facility rrier–Queen Fun	eral Home	and Crematory, P.A.
			23a. Part1. Enter the disease, or complications that caused	the death. Do not ent			nfield, MD 21784
	Physician		shock, or heart failure. List only one cause on each lir Immediate Cause (Final	he.	221 021	(1)	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as	a consequence of):	nai Laci	ure	73047
	Examiner		Sequentially list conditions.	ngestive	2 heart Ra	illure	years
	sit sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a con secuence of):	U		
	and al-tran	Examiner	that initiated events c.	a consequence of):	<u>_</u>		
68760,	icate be executed physician and s the burial-transit	calE	d				
	tificating phy as the	ledical					
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome 1 □ Live birth		Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	time of death 5	Other (specify)		Month Day Year
٣.	that the	y Ph	Part II. Other significant conditions contributing to death bu	ut not resulting in the u	nderlying cause given in Part I.	23e. Did	tobacco use contribute to the cause of death?
rds	w requires been sign should be	ed by	Coronary ante	ry dis	ease	1	Yes 2 No 3 Probably 4 □Unknown
Vital Records,	aw requ is been 2 should	Completed	$\sim$	$\sim$		24a. Was	
Ä	reicien: The law s certificate has t lirector, page 2 s	E O				perfe	pormad? death?  1 Yes 2 No
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?			Death (Check only	one)
<u>o</u>	shyei this c al dire	70		nt 2 ER/Outpatier			idence 6 Other (Specify)
Division of	Attending Phyeicien: sr death. ector: After this certifics by the funeral director.	Certification;	1 XNatural 5 ☐ Pending (Month, Day		f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No		how injury occurred
/Si	Atten r deat sctor: by the	ifica	3 Suicide 6 Could not be 28e. Place of Inju	iry - At home, farm, str		28f. Location (	Street and Number or Rural Route Number,
á	s after al Direct	Cert	4 Homicide determined building, etc.	: (Specify)		City or 10	wn, State)
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or in	n occurred at the time, date and povestigation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	o the ithin 2 o the omple	Med	one) and manner sta  29b. Signature and title of certifier	190.	29c. License number		29d. Date signed (Month, Day, Year)
	r s r ö	_	· = ZAH .	MD	D 00475	34	8/26/05
1	50		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print)		<del></del>
_	-		Natik I bralim Zaki 31. Date filed (Month, Day, Year) 32. Receive	r's Signature	VID		
4	Sta	e	or. Date med (mem, buy, real)				

			1 - State Registrar		artment of Health and rtificate of Death		ene g. No. 200	5 28471
П	Physici	an	1. Decedent's Name (First, Middle, Last)			Date of Death     Month	n Day Yea	3. Time of Death
	/Medic		Despima		Kaminaris	August	28 200	M
	Examin	er	4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Location of De	ath	4c. County of De	path
			Future Care Canton Harbo		Baltimore			NA
	Funeral		1□M 2□F	. Age (In yrs. last birthday)  OF Yrs.	If Under 1 Year If Under 24 H Months Days Hours M	in. (Month, Day,	Year) 9. 8	Country)
	Director		217-56-6298 X	85 Yrs.		July 20	1920	Greece
	/land		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Mar.	to	Maryland NA	Baltimo	<b>~</b> e			1 ☐ Yes 2 ☐ No
	or 28s	Directo	10e. Street and Number		10f. Zip Code	10	g. Citizen of What	Country?
	23a c	alD	518 South Newkirk Street		21224		U.S.A.	
	ams	ner	11. Marital Status 12. Was Deced	lent Ever in U.S. 13.	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian,
36	or it	by Funeral	1 Never Married 2 Married 1 Yes 2	ĭĬvo	1 ☐ Yes 2 ☐ No Specify:		Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Itams 23e or 28e-f show he Modeal Erafri her mutt ke trollfed an	q p	3 X Widowed 4 □ Divorced Year or Da	es:	Λ		Wh	nite
5	n 72 "nai	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of v DO NOT use retired)		6b. Kind of Busines	ss/Industry
12	withi	mc	Elementary/Secondary (0-12) College (1-8 NA	4or 5+)	Maker		Own Home	
	filed Hygid Sthar ent,		17. Father's Name (First, Middle, Last)	Tiome		lame (First, Middle, M		
an	lid be lental ked c	To Be	Nicholas	Gala	nis Iren	e	Ur	ıknown
Maryland	should Ind Mening Marke	_	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or			
	and 2 ealth a n 27 is		Gus Kaminaris ( Son )	3204	Peverly Run Roa	d Abington	, Marylar	id 21009
ore,	of He of He itam		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	ust 31,	0c. Location - City	or Town, State
altimore,	Pages nent of I ant: If its ury or o		1∑ Burial 2 ☐ Cremation 3 ☐ Removal from S  4 ☐ Donation 5 ☐ Other (Specify)	Oak I	1146		ast Point	, Maryland
alt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Estimation in the notified at once.		21. Signature of Funeral Service Incens	• // 22	Name and Address of Facility W. Dabrowski/Ch			
<u> </u>	<u>205</u> 29		Mark her	wiki.	1005 Dundalk Av	e. Baltimo	re. Marvl	
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not ent ch line.	er the mode of dying, such as card	iac or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	OPD				Onset and Death
h	/Medical Examiner		resulting in death)  Due to (c	r as a consequence of):				JU STACE
		-	Sequentially list conditions, b. A. B. O. C.	r as a consequence of:	byillation			
	ted nsit	nine	di any, lea ding to immediate due to (di cause. Enter Underlying Cause (Disease or injury		byillation			F 1
<b>,</b>	execun n and al-tra	Examiner	that initiated events c. Due to c.	r s a consequence of):	scor-			
8760,	sate be executed physician and the burial-transit	dlcal	d					
9	tificat ng ph) as th	led						
Вох	eath certific attending p I for use as	an/N	23b. Was decedent pregnant	ome of pregnancy th 2 Petal death 3	Ectopic pregnancy		23d. Date of d	
Э.	The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	Physiclan/Me	1 Yes 2 No 4 Pregna	nt at time of death 5	Other (specify)		Month	Day Year
P. 0.	that the de led by the a detached t	Phy	9 Unknown	ale leva ana annu leinn in stran		an Didash		4-4-1-2
Š,	signed d be de	by	Part II. Other significant conditions contributing to dea	) A	nderlying cause given in Part I.			to the cause of death?  Probably 4 XUnknown
0.0	w requir been si should	etec	Did, Demer	the , c	nesing	-		-
3ec	has by	Completed				24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of
<u>=</u>	sician: The certificate ha						No 1□Ye	s 2 No
₹	siciar certif	Be c	25. Was case referred to medical examiner?  Hospital:	0. T. T. T. T. T. T. T. T. T. T. T. T. T.	Cthor	eath (Check only one		
o	Phys	1: To	27. Manner of Death 28a. Date of		IL 3 DOA WINGISING	Home 5 Resident		лесту)
on	th. :: After	atlo	1 ∰Natural 5 ☐ Pending (Month 2 ☐ Accident investigation	Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	l or Attan after deat Director: I in by the	ertification:	3 Suicide 6 Could not be	of Injury - At home, farm, str g, etc. (Specify)	eet, factory, office	28f. Location (Stree		Rural Route Number,
	tal or A s after al Dire ed in b	Cert	Dullan	g, etc. (Specify)		Sity of Youri,	State)	
	l hour unar unar		29a. Certifier (Check only (Ch	est of my knowledge, death	occurred at the time, date and pla	ce, and due to the cau	use(s) and manner	as stated.
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	one) and manne	er stated.				
	Twin So		29b. Signature and title of certifier		29c. License number		d. Date signed (Mo	
	100		20 Name and address of activities	of death (Item 22s) (T	D 17202	A	ugust 29,	2005
K	10		30. Name and address of person who completed cause			1 - 1 01000		
Ĭ	Sta	te	Sat Pal Dang M.D. 101 St.  31. Date filed (Month, Day, Year)  AUG 3 1 2005	gistar's Signature	Daltimore, Mary	land 21222		
	Registr	4	AUG 3 1 2905 ▶	Distre St.	Marie			

			1 - For State Registrer	State of M	arylan	•	artment rtificate			ind M	F	Reg. No.	200	5	281	+72
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  Arsena F. Larmer  4a. Facility Name (If not institution, give s  20516 Afternoon L					Town, or	Location of	f Death	2, Date of Dea Month 08	Day 24		05 eath	3. Time of D	M 5a
	Funeral Director		5. Social Security Number 6. Sex 577-16-7585	7. Ag M 2 <b>②</b> F	92	ast birthday) Yrs.	If Under		If Under 2 Hours	Min.	8. Date of Birtl (Month, Day 10-11-	h , Year) -191:	9.	Birthpla Country	ce (State or i	Foreign
	e Maryland 8a-f show tiffied at	ctor	10a. State 10b. County MD Montgome	ery		, Town or Lo ermant								100	f. Inside City	
	ath with the 23a or 24	Funeral Director	10e. Street and Number 20516 Afternoon La				10f. Zip	Code	2087	4		-	sen of What	Countr	y?	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23a or 28a-f show important; if Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exstrict must be notified an once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 □ Yes 2反 If Yes, Give Year or Dates:	Ever in U.: No		Was Decede f Yes, speci l ☐ Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto F	cify Yes or No- Rican, etc.)	İ	4. Race - A Black, V Specify: ↓	Vhite, etc	c.	
Maryland 21215-0036	d within 72 h giene. or than "netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5	5+)	_	lent's Usual kind of work DO NOT use Creta	k done d e retired)	tion uning most	of workin	g		of Busine		of Co	ommer
yland	ould be file Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last)  James Fopless	,			18. Mother's Name Unobta			btai	me (First, Middle, Maiden Surnam ainable					
, Mar	and 2 sh salth and n 27 ia m		Judith L. Holton/o			20:	516 A:	fter			Route Numbe German					
Baltimore,	Pages 1 ment of He ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	CE	lace of Disposemetery, cremesapea.	natory or oth	her place	1		7-2005		cation - City eltsvi			
Balt	permit. Depertr Import. eny inj		21. Signature of Funeral Service License	man	10038		Name and Rapp 1	Fune	ral &	Cre	mation r Sprin	Serv	rices	0		
8760,	Certificate be executed Again diring physician and tree as the burial-transit	cal Examiner	Sequentially list conditions, larry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or an	в полвери	rence of):			ascu].							
.O. Box 6	death certifi e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	2 Fetal	death 3 🗌	Ectopic pre					2	3d. Date of Month	delivery D	ay Ye	ar
rds, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions conf	ributing to death b	ut not resu	lting in the un	iderlying ca	use give	n in Part I.		23e. Did to		1	e to the	cause of dea	
al Records,		e Completed	Ar Wasser to State							_		sy med? 2 X No	24b. Were prior death	to comp	y findings av letion of cau	railable ise of
	Attending Physician: r death. ector: After this certific. by the funeral director,	To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatie 28a. Date of Inju (Month, Da		ER/Outpatient 28b. Time of Injury		c. Injury Work	r: 4 🗌 Nurs	sing Hom	(Check anly or e 5 🖾 Reside 3d. Describe he	ence 6		pecify)		
Division	tal or Atters after afte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulg	ury - At hor c. (Specify)	me, farm, stre	eet, factory,	office		28	Bf. Location (Si City or Town		Number or	Rural F	Route Numbe	∋ <i>Г</i> ,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Exa	cian: To the best of and manner sta	examınatı	vledge, death ion and/or inv	estigation, i	License	nion, death	place, ar occurre	d at the time, d	ate and p	place, and o	due to th	e cause(s) y, Year)	
.7	W)		Marne and address of person who con	Ro Na	ath (Item	23a) (Type. F	Print) /	D5	1916	7		Hu	gust	- 2	15,20 ND 20	25
	Sta	ite	31. Date filed (Month, Day, Year)	Vay My	ar's Signat	119 Ri	ocku	ille	Pik	e, (	3-100,	Roc	kvil	le, 1.	ND 20	1852
	Registr		AUG 3 1 20	JUD JUD	HED.	10. 19	1									

			1 - State of Maryland / Department	artment of Health and Me rtificate of Death	ntal Hygie	2005 28473
I	Physici		Decedent's Name (First, Middle, Last)     Dorothy Marie Linthicum	-	Date of Death Month  Mugust 28	Day Year 3. Time of Death 6:30 A M
N.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	lugust 20	4c. County of Death
	1		13619 Jacobs Rd.	Mount Airy		Frederick
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 59 Yrs.	Months Davs Hours Min.	Date of Birth (Month, Day, Ye)	ar) 9. Birthplace (State or Foreign Country) Virginia
	D		Usual Residence of Decedent		CD 2, 1,	
	farylar show	ō	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the N	Funeral Director	MD Frederick Mount Airy  10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	h with	i D	13619 Jacobs Rd.	21771		Ited States
	ems semi	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric		14. Race - American Indian, Black, White, etc.
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "netural", or Items 23e or 28a-f show evant, the Medical Examination in the Lodified at	by FL	1 Never Married 2 Married 1 ☐ Yes 2 K No	1 ☐ Yes 2 ☑ No Specify:	,	Specify: White
9	2 hour	ted t	15. Decedent's Education 16a. Decedent	dent's Usual Occupation	16b	. Kind of Business/Industry
212	ithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)		
7	iled w tygier thar th	Col	12th Compu	ter Sciences  18. Mother's Name ()		ata Entry
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "netural; or Items 23e or 28a-f show any injury or other traumatic evant, the Medical Extra in that the notified at Once.	To Be	Arthur Kelyon Sink	Odessa Lin		
ary	s mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Rural F	Route Number, Cit	ty or Town, State, Zip Code)
χ̈́	and 2 ealth m 27 I			Jacobs Rd. Mount A		
Baltimore,	ages 1 nt of H : If ita or ot		T Dulla: 2 23 Clettation: 3 Themoval notes State	sition (Name of Dat matory or other place)		. Location - City or Town, State
Ħ.	artmer ortant injury		the state of the s	L1 Crematory 8/30/20 2. Name and Address of Facility	005 Wi	nfield, MD
Ba	Pen Jany Pen Jany		bu bu	rrier-Queen Funeral 12 W. Old Liberty R	Home an	d Crematory, PA
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  metastatic neuroei a	ndocrine cancer		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
		Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)  Cause (Disease or injury)			
	ocuted nd transit	Examiner	that initiated events			
8760,	cate be executed oblysician and the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):			
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	d			
Вох	eath certific attending p I for use as	M/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	∃Ectopic pregnancy		23d. Date of delivery
о. П	ie deal the att hed fo	sicle		Other (specify)		Month Day Year
<u> </u>	res that the digned by the be detached		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
Division of Vital Records,	quires n sign uld be	ed by			1 🗆 Yes	2 ☐ No 3 ☒ Probably 4 ☐Unknown
ဝ၁	law requir as been si 2 should l	ompleted			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ž		Com			performed	? death?
Vita	Physician: r this certificated director,	Be	25. Was case referred to medical examiner?	26. Place of Death (0		
ō	y Phys er this eral di	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of		5 🙀 Residence d. Describe how in	
on	Attanding I r death. actor: After by the funer	atlo	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
<u>i</u>	or Attano after death Diractor: in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f	Location (Street City or Town, St	and Number or Rural Route Number, ate)
	pital ours a laral Diaral Dilled i	Ce	29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and	due to the cause	b(c) and manner as stated
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date	and place, and due to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
,		2	1 6/1/	MD 33/09	Ale	16UST 29,2005
1	10		30. Name and address of belief who completed cause of death (Item 23a) (Type,			
	Sta	ite	3800 Reservoir Rd. NW Washington DC 20 31. Date filed (North, Day, Year)  AUG 3 1 2005  AUG 3 1 2005	OUU/ Jim Wong, MD		
4	Registr	ar	AUG 3 1 2005	silv.		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Allqust 21 Catherine Lane 2**6**05 6:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tate Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct 9 Birthplace (State or Foreign Country) **Funeral** 1□M 2√2 F 216-14-8994 99 Director 1905 Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "netural", or Itams 23e or 28e-f show other traumatic avant. The Modical Exemples in usit to notified at Maryland Anne Arundel Annapolis 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 3 Hicks Avenue 21401 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene.

is marked other than "netural", or Itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife N/A 12th 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mitchell Wade Clara Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is rr any Injury or other traum. Ronald Pindell(Grandson) 3 Hicks Avenue Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Brewer Hill Ceme. 8-26-05 Annapolis, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. y H. Reese MOG 483 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Wart **Physician** ouges 40E disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Henknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 Yes 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) TOS RCCE 1 | Yes 2 | → NO 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 28c. Injury at Work? After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funaral D 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)30718 dress of person who completed cause of death (Item 23a) (Type, Print) Pkuy Sk. 100 Annapolis mb 2140 Registrar

State of Maryland / Department of Health and Mental Hygiene Amend Item #5&8 Per Inf C847 9/29705 Inf C847 9/29705 Reg. No. 2. Dete of Death Month Dev Year Physician Matthews 35 Am Dla ust 30 2005 400 /Medical 4b. City, Town, or Location of Death Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Brightwood Nursing takeling
7. Age (In yrs. lest binthay)
Yrs. (renesis Lutherville 8. Date of Birt 10-29-1918 intholace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 212 12 12 19 324 **Funeral** Days Months Hours 1□ M 200€ Yrs. 64 Director Usuel Residence of Deceden filed within 72 hours after death with the Meryland 10a. State 10b. County 10c. City, Town or Lecation Inside City Limits 7 is merked other than "natural", or items 23a or 28a-f sho traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 2703 mont 21 bello 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 2 ZIN 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1□Yes 2XNo Specify: Be Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) dean Lc.an NA end Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) 18 . Pages 1 end 2 should be fill thent of Health end Mental H. tant: If item 27 is marked out ones mas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Backs. md . 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) monte mace Riles dayothe other t 20c. Location - City or Town, State 20a. Method of Disposition /Date 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) ò Crematory 05 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 34905 W. F ne al pastomd. nance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the model of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. lace Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ere boro vascular Examiner Due to (or es a consequence of) Be Completed by Physician/Medical Examiner or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🥦 Unknown DISEO 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 should 3 X No 1 ☐ Yes 2 No ↑ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Matural 5 Pending investigation efter death.

I Director: Aff 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled Hospital 24 hours Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier completely (Check only one) within 2. To the F 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier 2059423 an 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Feinbers Good Sameritan Hospital 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 3 2005 Registrar

			for State Registrar	State of Ma		epartment of Certificate of		l Mental Hygi	ene 200 !	5 28476
	Physici		1. Decedent's Name (First, Middle, L.) Reginal d	B	Ma	nning		2. Date of Death Month Au 9	Day _ Ye	3. Time of Death ar OOS 1445 M
	/Medic Examir		4a. Facility Name (If not institution, gir		d M.du		n, or Location of De		4c. County of D	-03
- 15	- Funeral	10	,		(In yrs. last birt			rs. 8. Date of Birth	9.	Birthplace (State or Foreign
191	Director	ij.	216-42-8750 Usual Residence of Decedent	1 💢 M 2 🗆 F	59	rs. Months Da	ys Hours Mi	n. (Month, Day)	346	*Waryland
	anyland show	_	10a. State 10b. County		10c. City, Towr		Baltimore			10d. Inside City Limits
	the Ma 28a-f	Director	Maryland I	I/A		10f. Zip Cod		10	g. Citizen of What	1 Yes 2 No
	23a or	ral DI	2022 Burnwood Road				21239			S.A.
9036	within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show the Medical Examinar must be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify C	Suban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		merican Indian, Vhite, etc. <b>Black</b>
Maryland 21215-0036	within ene. then "	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+		Decedent's Usual Oc (Give kind of work do life. DO NOT use rei	ne during most of w	vorking 1	6b. Kind of Busine <b>Dom</b> i	ess/Industry ino Sugar
land 2	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last	r Manning			18. Mother's N	ame (First, Middle, M. Hattie	aiden Sumame) B. Manning	
	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic.		19a. Informant's Name/Relationship	Туре, Print)	19b.	Mailing Address (Stre	eet and Number or I ood Road Ba	Rural Route Number, Itimore, Marylar	City or Town, Stat 1d 21239	e, Zip Code)
Baltimore,	Page Tent o Int: If		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other (Special Speci		cemeter	Disposition (Name of crematory or other p Forest Vetera	olace)	Date 29 09/07/05	Oc. Location - City Owings	or Town, State S Mills, Md.
Balt	permit. Pag Deportment Important: any injury o		21. Sign v 1 Fuñeral Selvice Lice	N ES	ten	1300	Eutaw Place,	eral Service, P. Baltimore, Md	. 21217 Balt	imore. Md.
<b>X</b>			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the	ne death. Do n	ot enter the mode of o	tying, such as cardi	ac or respiratory arres	t,	Approximate Interval Between Onset and Death
365	Physician /Medical		disease or condition resulting in death)	a. Abdu Due to (or as a	mun consequence o	u sepsi	2			
	Examiner	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	u. Multi	nsequence o	small &	sowel .	mla no		21 days
	cuted nd ransit	Examiner	that initiated events	Thurac	_ a l	domin	Jaur	-ic ane	Urysm	49 days
,09	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequence o	ison			1	1000
68760,		Aedical	TE FEMALE	d	2040.					10915
.O. Box	that the death certifined by the attending detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death	3 □Ectopic pregnar 5 □ Other (specify)			23d. Date of o Month	delivery Day Year
۵.	8 P 9	٥	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlying cause	given in Part I.			e to the cause of death?  Probably 4 Unknown
Division of Vital Records,		Completed						24a. Was an autopsy performe	l prior t	autopsy findings available to completion of cause of ? es 2 No
Zi Zi	ysicier is certif directo	To Be	25. Was case referred to medical examiner?  1 □ Yes 20 No	Hospital: Inpatient	2 🗆 ER/Out	patient 3 DOA	No.	eath <i>Check only one</i> Home 5 Residence	o 6 □Other (6	
o uo	ding Ph h. After th funeral		27. Manner of Death  1 Patural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Ti	me of 28c. In		28d. Describe how		респу
Divisi	al or Attending Physicien: after death.   Director: After this certifical d in by the funeral director.	Certification:	3 Suicide 6 Could not b 4 Homicide determined		r - At home, farr (Specify)	n, street, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	To the Hospitel or Attending Physicien: which 2 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	edicalC	29a. Certifier Certifying Pt (Check only one)	ysicien: To the best of r niner: On the basis of en and manner state	kamination and	death occurred at the or investigation, in my	time, date and place y opinion, death occ	e, and due to the cau curred at the time, date	se(s) and manner and place, and c	as stated. ue to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	1	~		nse number		. Date signed (Mo	
,	1		30. Name and address of person who	completed cause of dear	Ultem 23a) /1	VDA. Print)	6111	$\alpha$	ug. ¿	21 2005
4	200		Mary to Ho	ely "	25,	Greens	street	Balti	nove, r	27 2005 ND 21201
	Sta Registra	_	31. Date filed (Molth, Day, Year)  AUG 3 1 20	Registrar's	s Signature	pade		,	•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Reg. No. 2005 Certificate of Death Decedent's Name (First, Middle, 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner mono MD 1ncess Anne 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🖾 F Months Hours Min 71 Yrs. Director September 18,<u>1933 Virginia</u> 214-22-0706 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at XXYes 2 No Director Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or Itams 23a 314 Somers Cove Apartments 21817 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2\No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes XXNo Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housekeeping Department of Health and Mental Hygis Important: If itam 27 is marked other any injury or other traumatic event, It once. Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ James Shores Mabel Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Elliott (Son-In-Law) 26689 Crackertown Road - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VFW Memorial Cemetery 8/31/05 Crisfield, Maryland 21. Signature of Funeral Solvice Vicensee / Cus - Cus - Cus - Mary Beth Bradshaw-Pruitt Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Asur 54 cms disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been si 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical examiner? 26. Plac of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Diract completely filled in by 1 filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

'n State

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

DR-USHA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NATESAN.

ORIGINAL

29c. License number

DO5/359

1415-5-DMSION ST SAUSBURY (71) 21604.

29d. Date signed (Month, Day, Year)

August 29 15 205

			1- For Amend Ite	m 20b per	of Maryl fh G8	and / Dep. 46 8-31-	artment of 05 tas rtificate o	Health and f Death	Mental Hyg	iene 200	5 28478
	Physici	an	1. Decedent's Name (First, Midd						2, Date of Death Month	h Day Year	3. Time of Death
¥.	/Medi	cal	ARCHIE	MORRI					ALIGUST	28, 200	
	Examir	ner	4a. Fecility Name (If not institution  TO HAS HOPKINS	SATULEW		L CENTE		, or Location of De SALTEM		4c. County of Dec	
	Funeral		5. Social Security Number	6. Sex		yrs. last birthday)	If Under 1 Yea	ar If Under 24 H			rthplece (Stete or Foreign
п	Director		243-60-3652	1 X M 2 □ F	64	Yrs.	Months Day	s Hours M	s. Date of Birth (Month, Day, Sept 28	,1940 <sub>No</sub>	ountry) rthCarolin
	and w		Usual Residence of Decedent  10a, State 10b, Count	v	10c	. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	ō	MD	N/A		Balti					1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number				10f. Zip Code		10	Og. Citizen of What C	ountry?
	th will	a D	2211 Jeffer:	son St.			212	205		U.S.A.	
21213-0036	72 hours after death with the Maryland insturel, or items 23s or 28s-1 show dital Examene must be invilled at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	rried 1 Tes	2∏No ive No		Was Decedent o If Yes, specify Ct 1 ☐ Yes 2 N		(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify: B1	ite etc
ה	hin 72 ho e. en *netur	Completed		nt's Education est grade completed	"	(Give	dent's Usual Occ	e during most of w	rorking	16b. Kind of Business	s/Industry
7	7 G S 7	dmo	Elementary/Secondary (0-12) 5 t in	College	(1-4or 5+)	life.	<i>DO NOT use reti</i> Laborei	red)		Construc	tion
0		a	17. Father's Name (First, Middle	, Last)			rapor e1		ame (First, Middle, M		CTOIL
	Aental Aental rked tic ev	To B	Archie C. I	Morrison				Cori	ne Garn	ner	
Maryland	and N		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town,								Zip Code)
Σ π`	and and m 27 m 27		Mary Morriso	on/wife_				cson St	. Balt <u>im</u>		
pallimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, any injury or other traumatic event, ance.		20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation		n State V	b. Place of Dispo cemetery crei oshell	nsition (Name of matory or other p	(ace)	Date 2	20c. Location - City or	Town, State
	it. Pa intmen intent: njury		`4 □Donation 5 □ Other (: 21. Signature of Funeral Service		4	<del></del>	Cameta	arv ISei	ot1,200 <u>5</u>	Balto.	, MD
<u>0</u>	Depa Impo sny ii		Calr	$\leq 2$		Ç.	ALVIN E	PRESTO	GS FUNEI	RAL HOME LTO MD 2	1213
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	each line.	leath. Do not ent	er the mode of d	ying, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ETAST						
	Examiner					sequence of):	. 0				
Q		Jer	Sequentially list conditions, if any, leading to immediate		(of as a con		- IN				
	cuted nd transii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
Š	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to	o (or as a con	sequence of):					
	physic	dicai		d.							
.O. DOX	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 P nant at time	etel death 3	Ectopic pregnan Other (specify)	су		23d. Date of de Month	livery Day Year
-	res that igned b be deta	by Pt	Part II. Other significant condit	ions contributing to	death but not	resulting in the u	nderlying cause g	given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
2	w require been sig should b	ed b	KI DNEY	FAILU	RE	<u> </u>			1 ☐ Yes	s 2 <b>⊠</b> No 3 □ P	robably 4 Unknown
Vital necolds,	law re as bei 2 sho	Completed							24a. Was an	24b. Were a	utopsy findings available completion of cause of
		Com							autopsy perform 1 X Yes 2	ed? death?	
	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?			-			eath Check on one		
5	Physician: this certificantal director,	.T	1 ☐ Yes 2 🔏 No 27. Manner of Death	Hospital: 1 💢		2 ER/Outpatien	I SLI DOA		Home 5 Resider		ocify)
DINISION OF	ding Ph h. After th funeral	tlon	1 XNatural 5 ☐ Pendi		nth, Day Yeer	njury	W	ury at ork? ⊒Yes 2 □ No	28d. Describe how	w injury occurred	
2	I or Attency after death Director: In by the	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	e of Injury - A	At home, farm, str			28f. Location (Stre	eet and Number or R	ural Route Number,
5	s after s after al Dire ed in by	Certification:	4 Homicide	build	ding, etc. (Sp	ecity)			City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after deals, as the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medical	Examiner: On the t	e best of my basis of exam oner stated.	knowledge, death unation and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	ce, and due to the cau	use(s) and manner a te and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	ər			29c. Licer	nse number	29	d. Date signed (Mont	th, Dey, Year)
_			Varie ]	Sand, M.	$\mathcal{J}$ .		R	LES 001	A	JGUST 25	2005
2	N	1	30. Name and address of person  1.055 INE	who completed cau	se of death (	Item 23a) (Type,	Print) Ba	YView	Medica	(J.HA	1) 21204
2			31. Date filed (Month, Day, Year	Daorig	, MLD	)	494	OEast	ein Ave	Batto.	md.
	Sta Registr	te	AUG 3 1	) 22.1	negistrar's Si	gnature	E. S				

			1 - For State Registrar	State of M	aryland	/ Depa	artment of He rtificate of L	ealth and Death	Mental Hy	gien/ Reg. N	201	05	28479
	Observator	*	1. Decedent's Name (First, Middle, L	ast)					2. Date of D	eath		· · · · · ·	3. Time of Death
	Physici /Medio		Robert Harol	l Philp	s				Aug. 2		2005	Year	8:20 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, g	ve street and number)			4b. City, Town, or	Location of Dea	th	4	c. County o	of Death	
			Northampton Manor				Frederic				reder		
	Funeral Director		5. Social Security Number 6. 157-03-2498	Sex 7. Ag	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	Hours Min	. (Month, D	av. Yea	7)	9. Birthp Cou	place (State or Foreign htry)
L.			Usual Residence of Decedent		84				Uct.	.5,	1920	New	Jersey
	ylanc		10a. State 10b. County		10c. City, 7	own or Lo	cation					1	Od. Inside City Limits
	e Ma	Director	Maryland Frederic	:k	Freder	ick							1X Yes 2 □ No
	ith the	Olre	10e. Street and Number				10f. Zip Code			10g. C	itizen of W	hat Cour	ntry?
	death with the Maryland ms 23a or 28a-f show	ral	2507 Coach House				21702			USA			
	er de Items	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-		- America, White,	ean Indian, etc.
5	hours after tural', or Ite	by F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 💢 No	Specify:			Specify:	T.Th. 4	* •
5-0036	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Medical Executor must be notified a		15. Decedent's	Education	1	6a. Dece	ient's Usual Occupa	tion		16b. I	Kind of Bus	Whi iness/in	
7	within 72 ene. than "nat	ple	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or :	5+)	life.	kind of work done du DO NOT use retired)	uring most of wo	orking				f Defense
7	e filed wi al Hygien other th	Completed	12			Compu	ter Specia						
/iand	be fill d oth	Be	17. Father's Name (First, Middle, Las						me (First, Middle	_	_	,	
_	d Mer narke natic	2	Harold Wortman	Philps		401-14-18			Clevela		White		
<u>z</u>	as 1 and 2 should be of Health and Mental item 27 is marked or other traumatic eve		19a. Informant's Name/Relationship  Audrey Philps, wi		100		g Address (Street ar						
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. Plac	e of Dispo	Coach Hous		Date		ocation - C		21702 wn. State
Ē	ages ant of nt: If i		1 ☐ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Spec	Removal from State		•	natory or other place g Cremato	´ l	12005			•	
Бапптог	permit. Pages of Poppartment of Findontant: If ite any injury or of once.		21. Signature of Funeral Service Lic	•	SILL		. Name and Address						Maryland
ă	permi Depar Impor any ir		Kugu m. I	lergen	M009	99 1	06 East Cl	hurch St	reet, F	rede	rick	MD	21701
			23a. Part L Enter the disease, or cor shock or leart failure. List only	plications that caused									Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition				nfarction						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as									. вау
		_	Sequentially list conditions,	b. Coronar			isease						3 Years
Т	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	Ce or):							
,	execun and and all-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequen	ce of):			<del></del>				
00/00	tificate be executed g physician and as the burial-transit	edical		_ d									
	ntifica ng ph as th		IF FEMALE:						2 2010 100				
א כ	ath ce ttendii or use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth			Ectopic pregnancy				23d. Date		,
	the all	/slcl	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 🗆	Other (specify)				Mont	n	Day Year
	that the side by detac		Part II. Other significant conditions	contributing to death b	ut not resultin	on in the un	iderlying cause given	in Part I	23a Did :	obacco	uee contrib	udo to th	e cause of death?
ה מ	uires sign	d by	Diabetes Mellitu			g	and the second s	THE CONTRACT.		Yes 2	_		abiy 4 Unknown
5	w req	Completed		71					24a. Was				
ב	The la	dmo							auto perfo	psy ormed?	prii	or to con ath?	psy findings available inpletion of cause of
	an: Tiffical	O	25. Was case referred to medical	1				26 Place of Dec	1 ☐ Yes		1 _	Yes	2 L No
>	nysici nis cen direc	To B	examiner? 1 ☐ Yes = 2 🛣 No	Hospital: 1 ☐ Inpatie	nt 2 ER/	Outpatien:	3 DOA Other		lome 5 Resi	-	6 ☐Other	(Specify	)
5	ng Pt		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injui (Month, Da)	Year) 28	b. Time of Injury	28c. Injury a Work?		28d. Describe				,
2	tendi eath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not				M 1□Ye	es 2 No					
5	or At after d Direct in by	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home c. <i>(Specify)</i>	, farm, stre	et, factory, office		28f. Location (: City or Tox	Street ai wn, State	nd Number e)	or Rural	Route Number,
	spital ours s nerel filled		29a. Certifier 1X Certifying P	hysician: To the best of	of my knowled	dae deeth	Coourned at the time	data and place	and due to the		<b>&gt;</b>		
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edical	(Check only 2 Medical Exe	miner: On the basis of and manner sta	examination	and/or inv	estigation, in my opir	nion, death occu	rred at the time,	date an	d place, and	d due to	the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	1/			29c. License	number		29d. Da	te signed (	Month, L	Day, Year)
			٧ -	M			D51643		A	ugus	st 29	. 20	05
	18		30. Name and address of person with				Print)						-
	\	4	Hiren N. Shah, MD	00 0	. 0:			ederick	, Maryla	and	2170	2	
	Stat Registra		AUG 3 1	2005 32. Hagistra	r's Signature	1 1	selle						
			HUU 0 I	CO.O.O.O.O.O.O.O.O.O.O.O.O.O.O.O.O.O.O.	المراجع المستواد								

			State of Maryland / Department of Health and N  1- State of Maryland / Department of Health and N  1- State of Maryland / Department of Health and N  1- State of Maryland / Department of Health and N  1- State of Maryland / Department of Health and N		3	28480
_	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Elizabeth C Reinhardt	2. Date of Deat August 27		3. Time of Death 1:25 P
	Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
	100	著 等	Gilchrist Center  Towson  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birth	nnlace (State or Foreign
	Funeral Director		213 60 0993 1 M 2 T 76 Yrs. Months Days Hours Min.	Septembe	$r^{\frac{V^{eq}}{2}}$ 1928 Bal	pplace (State or Foreign intry) timore Co., MD
	pu *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	deeth with the Maryland ma 23a or 28a-f ehow Linual be invittled at	Ď	Maryland Baltimore Baltimore County			1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	
	23a c		8800 Walther Blvd. Apt 3409 21234		USA	
	er dee Itema uar m	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
_	036 urs after al', or its	þ	1  Never Married 2  Married		Specify: Whi	te
25pm	ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after deeth with the Marylan of Heelth and Mental hygiene. Item 27 is marked other then "netural", or items 23e or 28e-1 show other traumatic event, it is Medical Exercities must be rivilled at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ing	16b. Kind of Business/l	ndustry
23	within then.	mp	Elementary/Secondary (0-12) College (1-4or 5+)  12 N/A Homemaker		Lbradeonine	O n Homo
	d 2 High	Be Co	12 NA Homemaker  17. Father's Name (First, Middle, Last) 18. Mother's Name		Housekeeping- Maiden Sumame)	Jul Hole
5	should be nd Mental marked commetic even	To B	Ross Washington Fitch Freida Sop			
002	Maryland d 2 should be file th and Mental Hy 27 is marked oth traumatic event		19a. Informant's Name/Relationship (Type, Print)  Kenneth E, Hofstette  19b_Mailing Address (Street and Number or Rural Tipperary Ct.	al Route Number,	, City or Town, State, Zi	p Code)
17	e, N 1 and Heelth em 27 ither to		20a Method of Disposition 20b. Place of Disposition (Name of	<ul> <li>Baltimo</li> </ul>	re, Md. 21234 20c. Location - City or T	
N	ages ent of ht: If it y or o		1   Burial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)   Metro Crematory Inc August 30 20		Baltimore, Mar	
tayen	Baltimore, permit. Pages 1 at Depertment of Hee important: If item eny injury or othe once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		Extremible; FAC	710001
3	<b>0</b> 88 5 8		Lassahn Funeral Home In 7/41 Pelair Pool Peltin 23a. Part, Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac of the sused the death.		land 21236	
7			shock, or heart failure. List only one cause on each line.	or respiratory afre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Acute Leukemin			weeks
	Examiner		Due to (or as a consequence of):			
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
/	60, be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):			
5	1760, de tre be execu	icai E	Sub-to-(or-da-d-sur-su-q-sur-su-su-).			
ph	ox 687 certificate nding phys		d.		7	
A	Cords, P.O. Box 68 w requires that the death certifica been signed by the attending ph should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delive	very Day Year
112	O. En the death the death	sici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 9 □ Unknown		MORUI	Day real
M	ords, P.O requires that the een signed by the hould be detached.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
+	rds quires in sign	ed by	multiple inyeloma	1 🗆 Ye	es 2 DeNo 3 □ Pro	bably 4 Unknown
Wa	W W W	piet		24a. Was ar	n 24b. Were aut	opsy findings available
The	The The ete h	Completed		perform 1 ☐ Yes 2	ned? death?	2 No
S	of Vita Physician: this certific ral director,	Be	25. Was case referred to medicat examiner?  Hospital: 1   Legation   2   ER/Outpatient   3   DOA   Other: 4   Alureine Hospital: 1   Legation   3   DOA   Other: 4   Alureine Hospital: 1   Legation   3   DOA   Other: 4   Alureine Hospital: 1   Legation   3   DOA   Other: 4   Alureine Hospital: 1   Legation   3   DOA   Other: 4   Alureine Hospital: 1   Legation   3   DOA   Other: 4   Alureine Hospital: 1   Legation   3   DOA   Other: 4   Alureine Hospital: 1   Legation   3   DOA   Other: 4   Alureine Hospital: 1   Legation   3   DOA   Other: 4   Alureine Hospital: 1   Other: 4   Alureine Hospital: 1			11
E	Of Phys	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		once 6 Other (Special own injury occurred	ity) Itospia
	Vision of Attending For death.	ation	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
	Division  f or Attending efter death.  Director: After f in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Sti City or Town	reet and Number or Run , State)	al Route Number,
	Divisio  To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu		29a, Certifier 12G Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the co	usa(s) and manage as	state d
	Hos 24 hc	edicai	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	ate and place, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number		9d. Date signed (Month,	
	*		If Ansham Rily. NO 025205	1	Jugust 2,	1, 2000
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	It MI	21204	
	Mar St. St.	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  W. A. R. Ley G. B.M.C. 6701 M. Charles St. Bad  31. Date filed (Month, Day, Year)  AUG 3 1 2005	40-811 A		
	Regist		AUG 3 1 2005			

Lily Stoots 05-5702 AKG

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate of		d Mental Hyg	giene neg. No. 200	5 28481
	Physic		Decedent's Name (First, Middle, La Lily	est)		Stoots		2. Date of Dea Month August	Day Yea 23, 2005	3. Time of Death 5:20 P M
	/Medi Examir		4a. Facility Name (If not institution, git 1104 Meridene Dr			4b. City, Town, Balti			4c. County of De	
	Funeral Director		218-28-0336	Sex 7. Age 1 ☐ M 2 X F	71 Yrs.	Months Days		Hrs. 8. Date of Birth (Month, Day)	9. B 7. Year)	irthplace (State or Foreign Country) S.C.
	Maryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County  Md. N A	4	10c. City, Town or L	cation timore				10d. Inside City Limits 1 🛣 es 2 □ No
	with the	Funeral Director	10e. Street and Number 1104 Meridene	Dr.	L	10f. Zip Code 2123	9	1	10g. Citizen of What	
9036	72 hours after deeth with the Maryland 'naturei', or itame 23e or 28e-f ehow dical Examinar must be notified at	ρ	11. Marital Status  1 Never Married 2 Married  Midowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Pes 2 N If Yes, Give Year or Dates:	40	If Yes, specify Cult  1 ☐ Yes 2 【X No	oan, Mexican, P Specify:	? (Specify Yes or No- uerto Rican, etc.)	Black, Wi	Black
Maryland 21215-0036	within than than	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 8th grade	ducation ade completed) College (1-4or 5	+) (Give	ident's Usual Occu e kind of work done DO NOT use retire U <b>rsin</b> g	during most of	working	16b. Kind of Busines Hospita	•
land 2	id be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Las Jacob	")	Prince			Name (First, Middle, ary	Maiden Sumame)	Prince
	12 sh h and 7 is m traum		19a. Informant's Name/Relationship Joseph Willie	(Type, Print) Son				r Rural Route Number reet, LA,		
Baltimore,	_ + = -		20a. Method of Disposition  1  Burial  Cremation 3  4  Donation 5 Other (Special			osition (Name of matory or other pla nount Ce		Date -3-05	20c. Location - City of Baltimore	
Balti	permit. Pages i Depertment of H Important: If ite eny injury or ot once.		21. Signature of Funeral Service Lice		2	2. Name and Addr March F.	ess of Facility		ore, Md. E. North	21202 Ave.
760,	ate be executed  Wedical  Wasicien and  We burial-transit  Property of the pro	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	clerotic C a consequence of): a consequence of):	ardiovas	cular D	isease		Onset and Death
.O. Box 68	death certific: e attending pl id for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	cy .		23d. Date of d Month	elivery Day Year
<u>α</u>	quires that I n signed by uid be dete	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in the a	inderlying cause gi	ven in Part I.			to the cause of death?  Probably 4 Dunknown
Vital Record sicien: The law requir certificate hes been si rector, page 2 should						W			med? death? 2 No 1 Ye	
			25. Was case referred to medical examiner?  1. ∀es 2 □ No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3 DOA Ot	han	Death Check only on ng Home 5 Aeside		ecifyat scene
Division of	ding P. After fune	Certification:	27. Manner of Death    Natural 5   Pending 2   Accident investigation 3   Suicide 6   Could not be			M 1	]Yes 2□No		ow injury occurred	
Ω	in State		4 Homicide determined	building, etc				City or Town		
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	22a Certifier (Check only one)  23a Certifying Physician: To the basis of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as stated.  23a Certifier (Check only one)  23a Certifier (Check only one)							ue to the cause(s)	
•	Tor with com	<b>≥</b>	29b. Signature and title of certifier  Pamels Ford	houl, nuo		l l	.M.E.	2	9d. Date signed (Mon August 24	
	5		30. Name and address of person who Pamelu E- Sou	thall, mi	111 Pe		t, Balt:	imore,Mary	land 2120	)1
	Sta Regist		31. Date filed (Month, Day, Year) AUG 3 1 20		r's Signature	NEW .				

Registrar DHMH 17 Rev 1/2001

			1- State of Maryland /	Department of Health and N Certificate of Death	Mental Hygier Reg. N	2005 28483
	7		Registrar  1. Decedent's Name (First, Middle, Last)	Commodite of Bodin	2. Date of Death	3. Time of Death
	Physici	an	SARL SAIN		Month D	Day Year
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		23 2005 5:47 PM 4c. County of Death
	Examir	er				
4-			6015 Ebenezer Road  5. Social Security Number 6. Sex 7. Age (In yrs. last b.	White Marsh  rthday)   If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimore  9. Birthplace (State or Foreign
	Funeral Director		219–30–7849 <sup>1໘M 2□ F</sup> 71	Yrs. Months Days Hours Min.	(Month, Day, Yea 07/19/193	ar) Country)
			Usual Residence of Decedent		101/19/19	34 Maryland
	show		10a. State 10b. County 10c. City, Tov	n or Location		10d. Inside City Limits
	Man f sh	tor	MD Baltimore White	e Marsh		1 ☐ Yes 2X No
	7 288	rec	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	36.0	0	6015 Ebenezer Road	21162	T	J.S.A.
	ours after death with the Maryla rai', or Itams 23s or 28a-f shov Exantre from the fruilled at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
ဟ	after or its	F	Armed Forces?  1 □ Never Married 2X Married 1 □ Yes 2X No	If Yes, specify Cuban, Mexican, Puerto	Ricari, etc.)	Black, White, etc.
03	alt, c	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or itams 23s or 28a-f show Ita M. Jisal Ext. ether it and be rediffed at	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	ina 16b.	Kind of Business/Industry
21	thin e.e.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	inc .	
21	ed withingiane.	Son	10	Sales Representative		tomobile Industry
pu	should be filed within 72 hours aft nd Mental Hygiene. marked other then "natural", or imatic event, It a Modical Exami	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	en Sumame)
<u> a</u>	Ment Ment	2	George Sain	Paulin	e (Unknown	1)
Maryland	2 2 3 3		19a. Informant's Name/Relationship (Type, Print)	p. Mailing Address (Street and Number or Run	al Route Number, City	y or Town, State, Zip Code)
	of Health item 27		Anna Sain (wife)	6015 Ebenezer Road -		
altimore,	of He of He if item		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of ary, crematory or other place)	Date 20c.	Location - City or Town, State
Ĕ	Pages nent of h ant: if ite ary or o			ns of Faith Cem. 08/2	7/2005 Ba	altimore, Maryland
alti	art and and		21. Signature of Funeral Service Licensee			Funeral Home, P.A.
m	Dep Imp		E. A. Karacha	11750 Belair Road -	Kingsvill	le, Maryland 21087
g.	* # #		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
П	Physician		Immediate Cause (Final	2 Cancer		Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence			
	Examiner					
		ЭЕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):		
	uted d ansit	Examin	Cause (Disease or injury that initiated events c			
, C	be executed sician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence	of):		
8760,	cate be executed physician and the burial-transit	dical				
9		led				
Вох	eath certifi attending I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat	n 3 □Ectopic pregnancy		23d. Date of delivery
	deat e att	icla	in the past 12 months?  4 Pregnant at time of death	5 Other (specify)		Month Day Year
0	that the de led by the a detached i	hys	9 Unknown			
۳,	The law requires that the death certifi tie has been signed by the attending tage 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death?
rd	w requires to been signer should be				1 🗆 Yes	2 ☐No 3 ☐ Probably 4 ☐Unknown
Vital Records,	s bee	Completed			24a. Was an	24b. Were autopsy findings available
Re	The lav	шо			autopsy performed?	
ta		d)	25. Was case referred to medical	26. Place of Deat	h (Check only one)	40 , 15 ies 25 iie
>	Physicien: this certificantal director,	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	Othor	me 5 Residence	6 □Other (Specify)
ō	a Physical controls		27. Manner of Death 28a. Date of Injury 28b.	Time of 28c, Injury at	28d. Describe how in	
O	th. : After s funer	to	Watural 5 ☐ Pending (Month, Day Year)  2 ☐ Accident investigation	Injury Work?  M 1 Yes 2 No		
Division	or Attendater deatler Director:	fice	3 Suicide 6 Could not be 28e. Place of Injury - At home, f	arm, street, factory, office		and Number or Rural Route Number,
ă	afte Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	ite)
	spite nours nere / fille		29a. Certifier Certifying Physician: To the best of my knowledg	e, death occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	nd/or investigation, in my opinion, death occuri	red at the time, date a	nd place, and due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
			Schudled Physicia	an D39758	{	3-24-05
•	j		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		
	6		Kevin Schendel LVD 9101 Franki	(Type, Print) in SQ Drive, Suite 32	1, BACTO	MD 21237
	Sta	ite	31. Date filed (Month, Day, Year) AUG 3 1 2005 32. Registrar's Signature	11 Annie		
h(j	Registr		AUG 3 1 2005 100000 1000000 10000000 10000000000	. Again		

SHIN

			1 - For Stete Registrer		State of	Marylan	d / Depa <i>Cei</i>	artment of F tificate of	lealth and N Death	Лental Нус	giene Reg. No.	200	5 2848	34
			Decedent's Name (First,	Middle, Las	it)					2. Date of Dea	ath		3. Time of Death	
	Physici /Medic		Anne B. Sy	zdek						Month August	26.		6:45P	М
	Examin		4a. Facility Name (If not ins		street and num	nber)		4b. City, Town, o	Location of Death			County of Dea		
			188 Hardy P	lace				Rockvi				ontgom		
	Funeral		5. Social Security Number	6. Se	ox □M 2X0F	7. Age (In yrs.	, ,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	h vYear)	9. Bir	thplace (State or Forei ountry) nsylvania	<i>g</i> n
	Director		209-14-8853		L M 2017	80	Yrs.			November	5, 19	924   Pen	nsýlvania	
	and and		Usual Residence of Deceder 10a. State 10b. C		-	10c. City	y, Town or Lo	cation					10d. Inside City Limit	ts
	Mary	ō	Maryland Mor	ntgome	rv	Roc	kville	3					1X Yes 2□N	10
	28a	Director	10e. Street and Number	regome	. <b>.</b>	1100		10f. Zip Code			10g. Citiz	zen of What C	ountry?	
	deeth with the Maryland ine 23a or 28a-f ehow r must be notified at	<u> </u>	800 Bowie F	Road				20852			Uni	ted St	ates	
	deeti	Funeral	11. Marital Status		12. Was Dece	dent Ever in U.	S. 13.	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	. 1	14. Race - Am		
30	be filed within 72 hours after deeth with the Marylan at all typiene. All typiene. All typiene. All the Macical Examinar must be notified at event, it a Macical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Div		1 ☐ Yes If Yes, Give Year or Da	2 <b>ሺ</b> No e		Tes, specify cuba 1 □ Yes 2X No	Specify:	nican, etc.)		Black, Whi Specify: V	te, etc. Vhite	
215-0036	2 hou	ed	15. De	cedent's Ed	ucation		16a. Deced	dent's Usual Occup	ation		16b. Kin	nd of Business	/Industry	
2	nin 7: na "na Medi	plet	(Specify only Elementary/Secondary (C		de completed) College (1-	40r 5+)	(Give	kind of work done of DO NOT use retired	ation during most of world)	king				
Z	giene giene er the	Completed	12		0011090 (1		Homer	naker				Own H	ome	
_	al Hyg d other	Be	17. Father's Name (First, M						18. Mother's Nam					
<u>Xa</u>	2 should be to and Mental I ie marked or raumatic eve	2	Chai			aitus	,			ella Pau				
Maryland	permit. Pages 1 and 2 should by Obspariment of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		19a. Informant's Name/Rel		• • • • • • • • • • • • • • • • • • • •				d, Rockv			Town, State,	Zip Code)	1
<u>က်</u>	Heelt Heelt em 2		Jon J. Syzde	2K/ SOL		20b. P	lace of Dispo	sition (Name of		Date TID		cation - City or	Town, State	_
2	ages ant of t: If it y or c		1 ☐ Burial 2 ☒ Crema 4 ☐ Donation 5 ☐ Ott			State	emetery, crer	natory or other plac	Augu	st 29,		•		
saltimore,	mit. F pertme cortan injur		21. Signature of Funeral Se			Mont	-	Crematorium					Maryland	-
ă	Depe Impo eny i		William a.			M0117			ss of Facility Imphrey Fun omery Aveni			MD 2085	0	
			23a. Part1. Enter the disea shock, or heart failure	se, or comp	olications that ca	aused the death	n. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
	Pnysician:		Immediate Cause (Final disease or condition	•					Aneurys				6 months	
	/Medical		resulting in death)		d	or as a consequ								
	Examiner		Sequentially list conditions		D			<i>l</i> ascular	Disease				years	
	sit	lner	if any, leading to immediate cause. Enter Underlying	~	Due to (d	or as a consequ	uence of):							
	and and Il-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last		c. Due to (c	or as a consequ	uence of):					_		_
8/60,	icate be executed physicien and s the burial-transit	dical		l	d									
	ificate g phy as the	<b>a</b>			ч.									
ŏ	death certif e ettending id for use a	Z	IF FEMALE: 23b. Was decedent pregna	int	23c. If yes, outo	come of pregna	ncy	1 <del>-</del>			2:	3d. Date of de	livery	
		Physician/M	in the past 12 months 1 ☐ Yes 2 🛣 No	?		ant at time of de		Ectopic pregnancy Other (specify)				Month	Day Year	
	at the	h.	9 Unknown											$\dashv$
v)	requires that the neen signed by th hould be detache	þ	Part II. Other significent co						en in Part I.				the cause of death?	
cords,	een s een s	ted	Hypertipide	шта, г	11 6111 1 6 1	s, Hype	Jeny 10.	LUIDIII		1814	es 2 L	JNO 3 P	obably 4 Unknow	m
ည စ	as as	Completed								24a. Was a autop	sy	prior to	utopsy findings availab completion of cause of	le f
<u> </u>	i: The icete ha									perfor 1 ☐ Yes	2 💢 No	death?	2 □ No	
VITA	sicler certif recto	o Be	25. Was case referred to m examiner?		Hospital:			Oth	26. Place of Deal			7.5	in Vehicle	-
ō	Phys r this ral di	$\vdash$	1 X Yes 2 No 27. Manner of Death	1	1 ∐ In 28a. Date o		ER/Outpatien 28b. Time of	I 3 DUA	4 ☐ Nursing Ho	ome 5 ☐ Resid 28d. Describe h			in Vehicle in line	4_
0	th. : Afte	흝		Pending nvestigation	(Month	h, Day Year)	Injury	28c. Injun Work	<br Yes 2 □ No		,,			
DIVISION	Atter	ertification;	3 ☐ Suicide 6 ☐ C	Could not be	286. Place	of Injury - At ho	me, farm, str	eet, factory, office					ural Route Number,	
5	tal or s afte al Dir ed in	Cert	4   Hornicide		buildin	ig, etc. ( <i>Specif</i> y	′′			City or Tow	n, State)			
	To the Hospital or Attending Physicien: Th within 24 hours atter death.  To the Funeral Director: After this centificate completely filled in by the funeral director, pag.	edical	29a. Certifier 1 1 Ce (Check only 2 Me one) 1 Me	rtifying Phy dical Exem	ysicien: To the liner: On the ba	sis of examinal	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) a late and p	and manner as place, and due	s stated. e to the cause(s)	
	To the	Me	29b. Signature and title of c					29c. Licens	number	2	29d. Date	signed (Mont	h, Day, Year)	
			Donge	es.	Alexan	les,	200	D273	01		Aug	ust 29	2005	
ſ	M		30. Name and address of p	-		of death (Item	23a) (Type,							
_	0		Douglas R.					ntgomery	Avenue,	Rockvill	.e, M	ID 208	50	
	Sta Registr		31. Date filed (Month, Day, AUG	Year) 3 1 21	.007	gistrar's Signa		and a						
_		_			1.10	THE PARTY OF	-			-				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28485 For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) AUCUST Ergy. 20185 Physician 4:35P Storey Elouise /Medical 4c. County of Death Baltimore 4a. Eacility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death Examiner OWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** 1 ☐ M 2 🖾 F NorthCarolina 81 Aug 1,1924 Director 230-22-1447 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ? is marked other then "naturel; or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 U.S.A. 33rd St. Apt. 1020 E. death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filled within 72 hours after w Health and Mental Hygiene. em 27 is marked other then "naturel", or itei 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3altimore, Maryland 21215-0036 þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home 8th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvina Blount Henry Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) contant: if item 27 is injury or other tra-R. Storey/daughter836 Mildred Ave. Baltimore, MD 21222 Constance 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Denial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. KingMemorialPark Sept.2,2005Randallstown,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE, MD 21213 23a. Part1. Enter the disease, or complications that clused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DIFFUSE INTRAVASCULAR THROMBOSIS Immediate Cause (Final Physician disease or condition resulting in death) /Medical CORONARY ARTERY DISEASE Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed ACUTE RIGHT VENTRICULAR INFARCT 5 DAYS Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐ Yes 2 No detached the 9 Unknown 9 Illnknown ۾ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ◯ No 24a. Was an autopsy 2 No certificate 1 Tes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) aminer' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an D38570 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p JEFFREY SELL M. D. SUITE 410 7505 OSLER DRIVE TOWSON, MARYLAND 21204 32. Registras Signature 31. Date filed (Month, Day, Year) State Registrar

			T - State Registrar	State of Maryla	nd / Depa	artment of H	ealth and l Death	Mental Hyg	giene 2005	28486
			1. Decedent's Name (First, Middle, Last	)				2. Date of Dea	ath	3. Time of Death
	Physici /Medic		PHILLIP	STOKES				AVAVS	t 25, 2000	2:15P M
	Examin	er	4a. Facility Name (If not institution, give 6000 Gamarit	street and number)	al	4b. City, Town, or	nove		4c. County of Death	
	Funeral Director			7. Age (In yr.	s. last birthday)  Yrs.	ff Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day	y, Year) Cou	place (State or Foreign intry) RGINIA
	land W		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Mary -f ehc	to	MD. N/A		BALTI	MORE			1	1X Yes 2 □ No
	a with the	i Director	10e. Street and Number 2501 VIOLET AV	E APT. 102	2 B	10f. Zip Code 21215	5		10g. Citizen of What Cou USA	intry?
36	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f ehow event, the Medical Evarificat mast be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?  112 Yes 2 □ NA R I	MY	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2☐√No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, White	
0	tural select		3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Edu	Year or Dates WWI		dent's Usual Occupa	ition		16b. Kind of Business/li	
21215-0036	within 72 ene. than "na	piet	(Specify only highest grad		(Give	kind of work done d DO NOT use retired)	uring most of wor	rking	BALTIMOR	E CITY
	filed with Hygiene ither thai	Completed	12TH		MAIN	TENANCE	MAN		HOUSING A	OTHORITY
Maryland	d be fill ental Hy ked oth ic even	To Be	17. Father's Name (First, Middle, Last)  GRANT STOKES				18. Mother's Nan ANNIE		Maiden Sumame)	
ary	should be and Menta marked umatic ev	F	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street a			er, City or Town, State, Zi	p Code)
	and 2 salth a n 27 le		BYRON STOKES (	SON)		THE RESERVE OF THE PERSON NAMED IN	CK AVE.	* ****	MORE, MD.	21206
Jore	ages 1 nt of He t: If iter / or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ I	lemoval from State	-	natory or other place	D P. P.T.	. 1,200	20c. Location - City or T	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 ie marked any injury or other traumatic e one.		4 Donation 5 ☐ Other (Specify, 21. mature of Funeral Service Licens	f -H -	22	. Name and Addres	VET.CE		OWINGSMII	LS,MD.
<u>m</u>	e e E e e		Permadene	1. Jonny	W 1		PRESTON	ST. BA		1213
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the de ne cause on each line.	ayn. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Kight Lu	ng co	lapse				
	Examiner		was a second and the	A COO! VATIO	in PI	neumou	11a			
	TD ≃	iner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Du to (or as a conse	equence of):					
	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of);			-		
8760,	cate be executed physician and the burial-transit	dicai E	l	d						
9	ing physics as the	Medi	IF FEMALE:							
). Box	that the death certifics ed by the attending pr detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	Pery Day Year
P.0	hat the	Phy	9 Unknown  Part II. Other significent conditions co		esulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records,	w requires that the been signed by th should be detache	ed by							′es 2 □ No 3 □ Pro	
eco	aw Isb	Completed						24a. Was autop	an 24b. Were aut	opsy findings available ompletion of cause of
= =	Th ate pag	Con						perfor	rmed? death? 2 ☑ No 1 ☐ Yes	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	r	th (Check only o		
of		n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3 DOA	4   Nursing n		lence 6 Other (Speci low injury occurred	fy)
Sior	Attending r death. •ctor: After by the fune	atio	1 Natural 5 Pending 2 Accident Investigation	(Workin, Day 70ar)	Injury		es 2 □ No			
Division	al or Att	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or Rur n, State)	al Route Number,
	o the Hospital or Attend within 24 hours after death o the Funeral Director: / ompletely filled in by the f	edical C	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sicien: To the best of my ki ner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the time vestigation, in my op	e, date and place inion, death occu	, and due to the orred at the time, or	cause(s) and manner as s date and place, and due t	stated. o the cause(s)
	within 2 To the To mplet	Me	29b. Signature and tifle of certifier	her mr	)	29c. License		1	29d. Date signed (Month,	
1	10		Funda	1 -			3 000	) (	08/29/200	٥٠.
1	)		30. Name and address of person who can Indvani Mukney		em 23a) (Type,	Raven B	Vd. Ba	Himore	MD 2123	39
	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 1 20	32 Registrar's Sign	nature	ver			,	

DHMH 17 Rev 1/2001

Stokes, P. Grunt

Thomas H. Tate 05-05741 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

)	+1		1- State Unpend Item 23a,27,28a	land / Depa f per me Cei	atment of Heartificate of De	olth and Men 05 tas eath	tal Hygier	2005	28487
	Physic	ian	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year 2005	3. Time of Death
	/Medi	cal	Thomas H. Tate  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc		. 0	25 2005 4c. County of Deat	
	Exami	ner	16001 Shady Grove Road		Rockvill			Montgome	
	Funeral		Social Security Number	yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. 8, g	Date of Birth		nplace (State or Foreign untry)
	Director		219-46-8779 1XM 2DF 5	7 Yrs.	Months Days H	lours Min. MA	Month, Day, Yea R 7 194	8	DC
	and and		Usual Residence of Decedent  10a. State 10b. County 10	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl -f ahc	ğ	MD Montgomery	Rockvil1	e				1 □ Yes 2 🕏 No
	or 28e	Funeral Director	10e. Street and Number 16001 Shady Grove Road		10f. Zip Code 20850		10g. (	Citizen of What Co	untry?
	s 23e	erai		cin II C 12 V		nia Origin? /Conndu	Van er No	USA 14. Race - Amer	ican Indian
936	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Bany injury or other traumatic avant, Ira Medical Evaluical must be inclined at ance.	5	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Eve Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hispa f Yes, specify Cuban, W 1 ☐ Yes 2 🖾 No Si	Mexican, Puerto Rica	n, etc.)	Black, White	
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)		ient's Usual Occupation kind of work done durin		16b.	Kind of Business/I	ndustry
12	Men.	mple	Elementary/Secondary (0-12)  College (1-4or 5+)	life. I	DO NOT use retired)	g most of working	т.	0.7	
N	Hygie ther t int, in	S	17. Father's Name (First, Middle, Last)	ALL	orney	Mother's Name (Fir		an Sumama)	
a a	d be ental ked o	To Be	Samuel G. Tate, Jr.					rrison	
ary	and M	-	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and	Number or Rural Ro	ute Number, City	or Town, State, Z	ip Code)
Σ :	and 2 Belth n 27 i		Joseph Tate - Brother		Berryville	e Road, Ge	ermantow	n, MD 2	0874
	eges 1 ent of H nt: If Ite. y or oth		1 Burial 2 M Cremation 3 Bemoval from State		sition (Name of natory or other place) Crematory Inc	Date 8/31/20		Location - City or T	
Baitimore, Maryland	Depermit. It Depertm Importer any Injur		21. Signature of Funeral Service Licensee	22 20006 CA	Name and Address of FA. Stephen	Facility n D. Lohr	nann. PA		,
			23a. Part1. Enter the disease, or complications that caused the		17 Green Pa			wson, MD	21286 Approximate
	hysician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)  Narcotic  Due to (or as a co		ion				Interval Between Onset and Death
	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	ensequence of):					
8/60,	cete be executed physicien and the burial-transit	dical Examiner	that initiated events resulting in death) Last C. Due to (or as a co	ensequence of):					
/80	p phys	edlo	d.						
F.O. BOX	In a law requires that the death certaincele be executed the best been signed by the ettending physicien and bage 2 should be deteched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	very Day Year
, j	res mer igned b be dete	by Pi	Part II. Other significant conditions contributing to death but no	ot resulting in the un	derlying cause given in	Part I.	23e. Did tobacco	use contribute to	the cause of death?
	w require been sig should b	edt					1 🗆 Yes	2□No 3□Pro	bably 4 Unknown
DIVISION OF VITAL RECORDS,	ne law re sete hes be page 2 sho	Completed					24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
ובם	ysicien: is certifice director, p	Be C	25. Was case referred to medical examiner?		26.	Place of Death   Ch	10000	72.00	20.10
טו אוומ	this	၉	1 Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatient		☐ Nursing Home			
SIOII	After Fund	Certification;	27. Manner of Death  1 Natural  2 Accident  3 Suicide  6 Could not be	12:40	PM 28c. Injury at Work?		Describe how inj	ury occurred	unk
מאַ	1 5 5 E	Certifi	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 See Place of Injury building, etc. (S	At home, farm, stre pecify)	et, factory, office		ocation (Street a City or Town, Sta ckville,	and Number or Run te)16001 St Md	nady Grove 1
2	within 24 hours e To the Funeral completely filled	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my and manner stated.	y knowledge, death imination and/or inv	occurred at the time, destigation, in my opinion	ate and place, and d n, death occurred at	lue to the cause( the time, date a	s) and manner as s nd place, and due t	stated. o the cause(s)
F	withii To the	ž	29b. Signature and title of certifier		29c. License nur	mber		ate signed (Month,	
			30. Name and address of person who completed cause of death	(Item 23a) (Type, F	OCME		Aug	gust, 26,	2005
8			ANA RUBIO,	MD	111 Penn	Street :	Baltimor	e, Maryla	and 21201
	Sta Registr		31. Date filed (Month, Day, Year) 32. Projistrar's 3		cells				
DHM	H 17 Rev 1/2	001		~ 13					

State of Maryland / Department of Health and Mental Hygiene 2 1 1- State Regist SMEND ITEM #19a Per FH C846 8 PSTYGG AT Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGÜST 2005 Joan Dorothy Turnbull 6:15P /Medical 4a. Eacility Name (*If not institution, give street and number*) Saint Joseph Medical Center Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore TOWSON 7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
8. Date of Birth (Month, Day, Year)
7. Age (In yrs. last birthday)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, Year)
8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 1□M 2□F Director 213 26 3880 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-fehow 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9024 Hines Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 3 XWidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) School Crossing Guard Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I George Charles Steinbacher Ida Wrightson 19a Information Informant's Name/Relationship (ioanne D. Valent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health :: If itam 27 I 670 Laurel Drive Boiling Springs, PA 17007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Bel Air Mem. Gdns. August 30 2005 ` 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 22. Name and Address of Facility

Lassahn Funeral Home Inc 21. Ignatu e of Funeral Service Licensee 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA /Medical Due to (or as a consequence of); Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Liter Unitarying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DISEASE 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XiUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perfor 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 1. Nopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident s after dea. 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours tha Funaral Director Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To tha complet 29c. License number 29d. Date signed (Month, Day, Year) D41410 30. Name an addra's of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P MEHTA M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Thomas F. **Physician** Taylor, Jr. /Medical 08/28/2005 5:03am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1602 E. Clement Street Baltimore N/AIf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1**∑**M 2□F 218-58-5292 55 Yrs. Director 01/7/1950 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County Item 27 is marked other than "naturel", or Items 23e or 28e-f show other treumstic event, the Medical Examinating as 10d, Inside City Limits MD N/A Director 1√2 Yes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1602 E. Clement Street 21230 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No Unk. If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Item only injury or other treumatic event, the Medical Exercitations." 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 200 Completed by 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping 12 Time Keeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas F. Taylor, Sr. Lillian A. Budny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian A. Taylor/ Mother 1602 E. Clement Street, Baltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 08/31/2005 Baltimore MD Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore, MD 21230 Victor P.Doda Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Records, P.O. Box 68760. Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 212 No Division of Vital 1□ Yes Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mannet of Death After t 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending 1 Natural 5 Pending death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a

To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number wem.D 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Baltimore S. Hanover MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar book

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem per meo 2046 8-31-05 vt

		State of Maryland / Department of Health and Me		ene	r
Physicia		1. Decedent's Name (First, Middle, Last)  Jarod John Worneke Tarod John Worneke	2. Date of Death Month AUGUST 2	Day Year	3. 24 p M
/Medica Examine	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  HARFORD MEMORIAL HOSPITAL  HAVRE DE GRACE	9. Date of Pith	4c. County of Dea	th CO
Funeral Director		219-37-1425  12 Yrs. Months Days Hours Min. J. Usual Residence of Decedent	Month, Day, Y JAN 20 19	993	thplace (State or Foreign ountry) MD
within 72 hours after death with the Maryland ene. than 'natural', or items 23s or 28s-f show its Mudical Examinat routh to notified at	ector	10a. State 10b. County 10c. City, Town or Location  MD Harford Havre de Grace  10e. Street and Number 10f. Zip Code	100	. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
death with	Funeral Director	4201 Rock Run Road  21078  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	cify Yes or No-	USA 14. Race - Ame Black, Whit	erican Indian,
hours after turni', or its	2	If Yes, Give 1 ☐ Yes 2 🕱 No Specify: Year or Dates:			white
filed within 72 hours at Hygiene. Other than "natural", or ant, I're Medical Exert.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)  Student  (Give kind of work done during most of working life. DO NOT use retired)  Student	g E	Education	
d 2 should be file th and Mentel Hy ?7 is marked oth traumatic avant	To Be	17. Father's Name (First, Middle, Last)	н.	Hyson	Zin Codel
C = 14 F		Kimberly Werneke - mother  4201 Rock Run Road, Hav  20a. Method of Disposition  20b. Place of Disposition (Name of completely comple	re de Gr	•	21078
permit. Pages 1 a Depertment of Hee Important: if itam any injury or othe anges.		4 Donation 5 Other (Specify)  1. Signature of Funeral Service Licensee  2. Name and Address of Facility  AFA Stephen D John		Beltsville PA	
Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition			21286 Approximate Interval Between Onset and Death
/Medical Examiner	ler	Due to (or as a consequence of):  Sequentially list conditions  b.			
cate be executed physicien and the burial-transit	dical Examiner	resulting in death) Last  Due to (or as a consequence of):			
The law requires that the deeth certificate be executed ate hes been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months? 1		23d. Date of del Month	ivery Day Year
he law requires that e hes been signed b		Part it. Other significant conditions continuum to death out not resulting in the underlying cause given in Part i.	23e. Did tobac		o the cause of death?
	Completed		24a. Was an autopsy performer	d? prior to death?	utopsy findings available completion of cause of 2 □ No
ding Phys	Certification; 10 Be	examiner?  1 X Yes 2 No  Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA  Other: 4 Nursing Home	e 5 Residence  Bd. Describe how  BTECT ON  CE ROPD  Bf. Location (Stree	SCOOTER C	ANE IND
Hospita 4 hours Funeral	Medical Cert		201 Rouk	se(s) and manner as	HAVE DE GARCE
To tha within 2 To tha complet	Mec	29b. Signature and title of certifier  29c. License number  O C M E	29d.	Date signed (Mont.) UGUST 26,	h, Day, Year)
N		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA KUBIO MD 111 PENN STREET, BA	ALTIMORE	, MARYLAN	D, 21201
State Registra	-	31. Date filed (Month, Day, Year)  32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month Year Physician /Medical 4c. County of Deeth Neme (If not institution, give str 4b. City, Town, or Location of Death Examiner Baltimore 10 46Old North If Under 24 Hrs. 8. Date of Birth (Month, Day, JAN 28 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days 1**⊠** M 2□ F 67 212-36-1545 Director Usuel Residence of Decedent death with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 7 is marked other than "natural", or flems 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No MD Directo Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street end Number 1046 Old North Point Road 21224 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. Peges 1 end 2 should be filed within 72 hours efter nent of Health end Mental Hygiene.
int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ white 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Cutter Factory 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry F. Wagner, Jr. Gladys Eugene Pettie 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Wagner - brother 247 West Main Street, Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cemetery 8/31/2005 Owin's Mills MD 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21. Signature of Funeral Service Licenses M00986 21286 23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physicien end I for use as the bunel-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initieled events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? cete has been signed by the page 2 should be deteched 3 Probably 4 Unknown ascular accident 1 Yes 2 No ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed has 2000 1. Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation Injury deeth. 1 Yes 2 🗆 No Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide efter Hospital 24 hours 29a. Certifier (Check only one) Fortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) Medicai completely and menner stated within 2 29b. Signature and title of certifice 29d. Date signed (Month, Day, Year) 29c. License number 00/1150 30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) 45 ELLWOOD AVE, BALTY MO ELITO RRES 32. Begistrer's Signature 31. Dete filed (Month, Day, 1 2005 Registrar

DHMH 16 Rev 6/95

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

		1 - State of Maryland State of Maryland		artment of H <i>rtificate of L</i>		nd Me	-	jiene	000	201.00
		Decedent's Name (First, Middle, Last)					2. Date of Dea	th	005	3. Time of Death
Physic /Med		Gloria Jean Wiederkehr					Month 08	Day 26	Year 2005	12:45 AM
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	Death	00		ounty of Death	12:45 AM
		Manor Care - Ruxton		Ruxton				Ba	altimor	e
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. las	it birthday)		If Under 24 Hours		8. Date of Birth		9. Birthp	lace (State or Foreign
Director		217-22-8594 <sup>1□ M 2</sup> The second of the sec	Yrs.	World's Days	Hours	Min.	(Month, Day) 09/07/1	925	Ma	ryland
pun *		Usual Residence of Decedent           10a. State         10b. County         10c. City,*	Town ort.							
laryla sho	5			ocation						Od. Inside City Limits
he M	Director	MD Baltimore Rux	ton							1 ☐ Yes 2 🙀 No
with B	ä	10e. Street and Number		10f. Zip Code			1	0g. Citizer	n of What Cour	ntry?
eath	Funerai	7001 North Charles Street  11. Marital Status 12. Was Decedent Ever in U.S.		21204					5.A.	
iter d	Š	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origir n, Mexican, f	n? (Spec Puerto R	iry Yes or No- ican, etc.)	14.	Race - Americ Black, White,	
urs af	by	3X Widowed 4 □ Divorced		1 ☐ Yes 2 X No	Specify:			Sp	ecify:	
d within 72 hours after death with the Maryland giene. er than "naturel", or items 23a or 28a-f show it he Modical Examiner must be notified at	ted	15. Decedent's Education	16a, Dece	dent's Usual Occupa	ıtion			16b Kind	Whi of Business/Ind	
hin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done d DO NOT use retired,	<i>luring</i> most o )	of working	7			,
gien that	no.	12	Hom	emaker				Омт	Home	
al Hy Vent	Be (	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (	First, Middle, M			
nd 2 should be file th and Mental Hy 27 is marked oth treumatic even!	70	George Freeling Grim			Agath	na R.	. Milbu	rn		
sho and l		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a					wn, State, Zip	Code)
and and alth		Lisa J. Weinstein (daughter)	200	2 Farm Po	nd Cou	ırt -	- Reist	ersto	wn. Mai	ryland 2113
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: It item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Modical Examination and page.		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State	e of Dispo	sition (Name of natory or other place		Da			ion - City or To	
Pag ment ent: b		1 Zapariar 2 Ecramation 3 Enamoval from State		Mem. Gdns		3/30/	/2005	Falle	ton Ma	brelvre
permit. Departr Importe any inju		21. Signature of Funeral Service Licensee			s of Facility	E. I	Lass	ahn F	uneral	Home, P.A
89888		C. F. Xassahw	1	1750 Bela	ir Roa	ad -	Kingsv	ille,	Maryla	and 21087
Physician /Medical Examiner	resulting in death)  Due to (or as a consequence of):								eng	Approximate Interval Between Onset and Death
ficate be executed physician and streets the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C								
death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)				23d.	Date of deliver Month	y Day Year
The law requires that the tte has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting	ig in the ur	nderlying cause give	n in Part I.			accouse o		a cause of death?
he law require e has been si ige 2 should b	iete						24a. Was an	24	Ib 14/222 21/22	
	e Compieted	25. Was case referred to medical					autopsy perform 1 Yes 2	,	death?	sy findings available apletion of cause of
Physician: rthis certificaral director, I	OB	examiner?	Outpation	Other			Check only o		0.11	
nding Physath. r: After this e funeral dii	ation; T	1   Yes   2   No								
To the Hospitel or Attending Physician: 1 within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		281	Location (Str. City or Town,	eet and Nu State)	ımber or Rural	Route Number,
To the Hospitel or within 24 hours aft To the Funerel Di completely filled in	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowle 2 Medicel Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time estigation, in my opi	e, date and p nion, death o	lace, and	d due to the car at the time, da	use(s) and te and plac	manner as sta	ted. the cause(s)
To t To t	Σ	29b. Signature and title of certifier		29c. License	number		29	d. Date sig	ned (Month, D	ay, Year)
		1/11 Ollastim		0-00	2116	349	7	8-	26-0	1
3	ं	30. Name and address of person who completed cause of death (Item 23 AH - GHLAD), MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature	а) (Туре, F	Print) OSLE	e D	Y. '	Tows	SON	MD	21204
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	4.	Lower						

			For State Registrar	State of Maryland	i / Department of Health and Certificate of Death	Mental Hygier	7005	28494
	Physici /Medic Examin	an al er	1. Decedent's Name (First, Middle, Benjamin) 4a. Facility Name (If not institution, 103 Harl	Washing	4b. City, Town, or Location of Deal  Ball MOV  Ist birthday) If Under 1 Year If Under 24 Hrs  Yrs. Months Days Hours Min	August	Day Year 2005 4c. County of Death A Sount A Sount A	3: 15 m  3: 15 m  ace (State or Foreign ry)
	Director  1 or 288-1 show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number	10c. City.	Town or Location  Baltimore  101. Zip Code	109.	Citizen of What Count	od. Inside City Limits 1   Yes 2   No
5-0036	72 hours after death with the Maryland neturel', or Items 23s or 28s-f show disal Examiner must be neillfied at	ted by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced  15. Decedent's	If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	to Rican, etc.)	14. Race - America Black, White, e Specify: B	ack
Maryland 21215	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 2 Health and I He	To Be Completed	(Specify only highest Elementary/Secondary (0·12)  17. Father's Name (First, Middle, Li Ben Iam I m  19a. Informat's Name/Relationshi	College (1-4 or 5+) Ist) Washingto	Recreational Ctr. Direc	tor II B me (First, Middle, Maio thy Sa	on Sumamb)	Rec+ParKs
Baltimore, Ma	permit. Pages 1 and 2.2 Department of Health at Important: If item 27 Is any injury or other trau once.	0.00	MCS, Barbaro  20a. Method of Disposition  1 Method of Disposition  4 Donation 5 Dother (Special Surviv	Washington 20b. Pla 1 (Bemoval from State)	ace of Disposition (Name of meter), crematory or other place)  Outus Mem, Park 9/2  22. Name and Address of Facility  Joseph L. Russ	Date 2005 P	Location - City or Tovalto. M	21217 vn, State
Ī	Physician /Medical Examiner	al Examiner	23a. Part I. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. AUTE  Due to (or as a conseque	Do not enter the mode of dying, such as cardia  MYOCARDIAL ence of):  BASIVE CARDIA US ance of):	INFARC	Tion	Approximate Interval Between Onset and Death
P.O. Box 687	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1   Live birth 2   Fetal of 4   Pregnant at time of dec	death 3 □Ectopic pregnancy		23d. Date of deliver Month	y Day Year
cords,	ie law requires that the death has been signed by the atter ge 2 should be detached for u	Completed by Pr	Part II. Other significant condition	<b>s</b> contributing to death but not resul	tting in the underlying cause given in Part I,	23e. Did tobacc  1  Yes  24a. Was an autopsy performed	24b. Were autop prior to com death?	ably 4 Unknown asy findings available apletion of cause of
ital	ien: Th rtificate ctor, pag	Be Co	25. Was case referred to medical examiner?			1 ☐ Yes 2 ☑ ath (Check only one)		
sion of V	To the Hospitel or Attending Physicien: The k within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page.	Certification; To I	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investige 3 Suicide 6 Could no	(Month, Day Year)	28b. Time of Injury M 28c. Injury at Work?  M 1 \[ \text{Yes} \ 2 \] No	Home 5/2 Residence 28d. Describe how in	ijury occurred	
Divi	el or Att s after d el Direct ed in by	Certifi	4 Homicide determin		ne, farm, street, factory, office	City or Town, St	and Number or Rural ate)	Houte Number,
	e Hospit 24 hour e Funer letely fills	edical (	29a. Certifier 12 Certifying (Check only one) 2 Medicel E	Physician: To the best of my know ceminer: On the basis of examination	viedge, death occurred at the time, date and plac on and/or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	o(s) and manner as sta and place, and due to	ated. the cause(s)
)	To th withir To th	Me	29b. Signature and title of certifier	ragen N.D.	29c. License number		Date signed (Month, D	
6	12		30. Name and address of person w	ho completed cause of death (Item	23a) (Type, Print) 4706 HART A-D BALTIMORE	ond na	n/2 3/2/4	2
	Sta Regist		31. Date filed (Month, Day, Year) AUG 3 1	2005 32. Registrar's Signatu	23a) (Type, Print) 4706 HARF h-D BALTIMORD Ure	,		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene of Copies

			1 - State of Maryland Registrar	Certificate of	Death		g. No.	15	28495
	Physici		Decedent's Name (First, Middle, Last)     CECILIA MAE PINDER AN	DREW		2. Date of Deat Month		Yeer	3. Time of Death  12:20 A <sup>M</sup>
*	/Medic Examin		4a. Facility Name (If not institution, give street and number)		or Location of Death	71001	4c. County o	f Deeth	
			CORSICA HILLS NURSING HOME		EVILLE		QUEEN		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 90	Yrs. If Under 1 Yea Months Days		8. Date of Birth (Month, Dey, JAN - 22	Year) 2,1915	9. Birthple Countr MARY	ace (State or Foreign ry) LAND
	death with the Maryland ims 23a or 28a-f show	_	Usuel Residence of Decedent  10a. State 10b. County 10c. City	, Town or Location				10	d. Inside City Limits 1 ☐ Yes 2X No
	Ba-f a	cto	MD QUEEN ANNE	CENTREVILLE					
	ith th	Director	10e. Street and Number	10f. Zip Code	(17	1	0g. Citizen of WI	naf Counti	ry?
	ath w 8 23a		1316 WHITE MARSH ROAD		617	acity Voc or No	USA 14. Race	- America	n Indian
_	be filed within 72 hours after death with the Marylan tall Hyglene.  I al Hyglene.  I other than "natural", or items 23s or 28s-f show other than "natural", or items 23s or 28s-f show event, I a Medical Exactinat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ▼Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	if Yes, specify Cu	Hispanic Origin? (Speban, Mexican, Puerto ban Specify:	Rican, etc.)	Black Specify:	White, e	tc.
3	hour	edt	15. Decedent's Education	16a. Decedent's Usual Occ	upation		16b. Kind of Bus		
Ç	n "na	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work don life. DO NOT use retii					
212	d with giene or the	Completed	10 -0-	HOMEMAKER			OWN	HOME	
$\subseteq$	D 2 2 0	To Be C	17. Father's Name (First, Middle, Last) LINWOOD PINDER		18. Mother's Name		BUCKLE		
a Z	d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stree	et and Number or Rura	al Route Number	City or Town, S	tate, Zip (	Code)
	alth a alth a 27 is		MARION F. ANDREW/ SON	160 ANDREW FA					
ore.	es 1 and of Healt fitem 2 r other		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State	ace of Disposition (Name of emetery, crematory or other pi	ace)		20c. Location - C	ity or Tow	m, Stete
Ĕ	Pages nent of ant: If it ury or o		'4 Donation 5 Other (Specify)	ENMOUNT CEMETE	RY 8-22-	-2005	HILLSBOR	RO, M	D
Baltimore,	permit. Page Department Important: I any injury o once.		21. Signature of Funeral Service Liberis	FELLOWS, H	ress of Facility ELFENBEIN BERTY ST.	& NEWNAL	M FUNERA	L HO	ME, P.A.
	EU		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not enter the mode of dy	ring, such as cardiac	or respiratory arr	est,	1	Approximate Interval Between
Y	Physician			NONIA					Onset and Death
	/Medical		resulfing in death)  Due to (or as a consequ						
H	Examiner		Sequentially list conditions b.						
	sit od	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ence of):					
	and and I-trans	хаш	that initiated events resulting in death) Last  C  Due to (or as a consequence of the consequence of	ence of):				-	7
68760,	be executed sicien and burial-transit								
387	ate:	edlcai	d						
ŏ			IF FEMALE: 23c. If yes, outcome of pregnar	ncy			23d. Date	of deliver	y
m	requires that the death certi been signed by the attending hould be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ■ No		су		Mont	h [	Day Year
o	the d	hysi	9 Unknown						
ري ص	res that the de signed by the a be detached t	by P	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause of	given in Part I.	23e. Did tob	pacco use contrib	oute to the	cause of death?
ğ	w require been sig should b	edt	INSULTN DEPENDENT DE	ABETES ME	ULITES	1 □ Ye	s 22 No	Proba	bly 4 ⊡Unknown
Vital Records,	> 11 ()	Completed	PERIPHERAL VASCUL	AR DISPO	45E	24a. Was a			sy findings available pletion of cause of
ž	Physician: The law this certificate has b al director, page 2 s	ē	SETZURE ATSORDER	>		perform	ned? de	ath?	No.
<u>ta</u>	ian: ntifica ctor, p	Bec	25. Was case referred to medical examiner?		26. Place of Death	n (Check only on	6)		-
<u>&gt;</u>	Attending Physician: It death. ector: After this certific by the funeral director.	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ E	EN/Outpatient 3 DOA		me 5 Reside			
Ē	ng (fer	on:	27. Manner of Death 28a. Date of Injury (Month, Day Yeer)		ork?	28d. Describe ho	ow infury occurre	d	
sio	tendi leath. tor: A	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 288 Place of Injury At hou		]Yes 2 □No	28f. Location (St	troot and Alumba	or Rumi	Pouto Number
Division of	호류등	Certification:	4 Homicide determined 288. Place of Injury 2 Al homicide building, etc. (Specify,	me, farm, street, factory, office )	•	City or Town		Or Fibrar	riodia ridinoar,
	Hospit 4 hour Funera ely fills	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.						
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	29c. Lice	nse number	2	9d. Date signed	(Moŋth, D	ley, Year)
	F 3 F 8		1 Zaid (Non int	MI	35045	3	8/17	1/20	205
			30. Name and address of person who completed cayse of death (Item	23a) (Type Print)	1, 5 16		OUT	100	
1	VL			NTREVILLE ROAL	), CENTREV	ILLE, MD	21617		
	Ste	ite	31. Date filed (Month, Dall (Ar) 7 8 200 82. Registrar's Signat						

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2005 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2:40 **Physician** August 19, 2005 Robert Lewis Anderson, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F Director October 20, 1915 Maryland 218-30-4488 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "naturel", or Items 23s or 28a-f shov other traumatic event, the Madical Exampler intellife inclined at 1 ☐ Yes 2XXNo Funeral Directo Maryland St. Mary's Clements 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20624 USA 23699 Budds Creek Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be tiled within 72 hours after I Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "naturel", or Ites any injury or other traumatic event. The Mettless Ferri 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cora Eva Williams James Briscoe Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 161, Clements, Maryland 20624 Virginia Pierce / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) St Joseph's Cemetery 24, 2005 Morganza, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Immediate Cause (Final disease or condition resulting in death) ovo Physician /Medical Due to (or as a consequence of): avdromyopathy Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner 1 brillation 1 orl the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last (or as a consequence of): neu monits 68760, pation Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an this certificate has autopsy 1 Yes 2010 To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certilics completely tilled in by the tuneral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22576 MacArthur Blvd. California, Maryland 20619 Manoj Panwala, M.D. 32. gistrar's Signatu 31. Date filed (Month, Day, Year) State AUG 2 3 2005 Registrar

DHMH 17 Rev 1/2001

Anderson

(cbert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 28497 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:40 P M 16 2005 August Ralph C. Adams, Jr. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Millersville 8231 Rupert Road North If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 18, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 11 M 2□ F **Funeral** Months 1939 Maryland 66 216 26 7178 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland hal Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo MD Anne Arundel Millersville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21108 United States 8231 Rupert Road North Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry The Mudical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed **HVAC** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h Ralph C. Adams, Sr. Esther Labinka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 ment of Health a ent: If item 27 is Linda S. Adams/Wife 8231 Rupert Road North Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Pege Department of Importent: If any injury or once. ö 8-19-2005 Good Shepherd Cem. Ellicott City, MD \* 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. ▶ 0 Chem 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Colon Cancer 3-100cs METASTATIL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit law requires that the death certificate be executed attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ģ in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 2 No 1 ☐ Yes page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 21 No 1 ☐ Yes 2 ☑ No Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 3□ DQA Certification; To 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 Pending To the Hosping.
within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature, nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 38509 August 17, 2005 of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, ) 32. F

DHMH 17 Rev 1/2001

State

Registrar

8

			1 - For State Registrar	State of Maryla	-	artment of H		nd Mental F	lygien Reg. N			
	Physici /Medi		1. Decedent's Name (First, Middle, Last, Duane 100	nard		Basa	hert	2. Date of Month	Death Da	2 U	05 Year 205	3.2m8142 8
	Examir Funeral Director	er	5. Social Security Number 6. %9:	ollins Hosp	s. last birthday)	4b. City, Town, o	7 M EM.	= Cite	Birth Day, Year		9. Birthpla Count	ace (State or Foreign ry) 'land
	the Maryland 28a-f show	ō	Usual Residence of Decedent  10a. State 10b. County  PA Adams	10c. C	City, Town or Lo						10	0d. Inside City Limits 1 ☐ Yes 25 No
	h the l	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of Wh	nat Count	ry?
	ath wil	raiD	320 McSherry W			173				ISA		
9036	ours after de ral', or items Examiner m	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin an, Mexican, F Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race Black, Specify:	White, e	
21215-0036	be filed within 72 hours after death with the Maryland nia! Hygiene. so other than "natural", or items 23a or 28a-f show event. Ite Macical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NDT use retired	during most of	f working	Ea	St Co st ing	ast	Concrete
	be de la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)					Name (First, Mide		,	)	
Maryland	should nd Men marke umatic	٦	George Adam Bos		19b. Mailir	ig Address (Street		ta Louise or Rural Route Num			tate, Zip (	Code)
	and and n 27		M/M George Boscherd	t Parents	3029	Kump Sta	tion R				217	
more,	Pages 1 nent of Hi int: If iter		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	lemoval from State	cemetery, cren	sition (Name of natory or other plac		/18/2005	1	ocation - C		
Baltii	permit. Pag Department Important: I any injury o		21. Signature of Funeral Serviced license	Me	22	anch Ceme	ss of Facility P		neral		& C	hapel, PA 157
	Priysician		23a. Paker. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the dea						<b>_                                    </b>		Approximate Interval Between Onset and Death
8760,	Medical Examiner  hysician and the purial-transit	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)	oquence of):	y Dist	·ess ·	Syndian			24.	Days
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)				23d. Date (		y Day Year
rds, P.	The law requires that the de Ite has been signed by the a rage 2 should be detached f	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.		tobacco		ute to the	cause of death?
Vital Record		Completed						1 Yes	opsy formed? 2 \(\sigma\) No	prid	or to comp ath?	sy findings available pletion of cause of
	this ald	To Be	162 2□140		ER/Outpatien		er: 4 🗌 Nursir	Death (Check onlying Home 5 Re	sidence			
Division of	fte lifte	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	yat <br Yes 2 □ No	28d. Describ	e how inju	ry occurred		
N N	al or Att s after de il Direct id in by t	Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre ify)	eet, factory, office			(Street ar own, State		or Rural I	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edicai (	29a. Certifier (Check only one) Certifying Phys	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	ne, date and p pinion, death o	lace, and due to the	e cause(s) e, date and	and mann d place, and	er as stat d due to t	ed. he cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	), (-		29c. License			29d. Da	te signed (/	Month, Da	ay, Year)
	WIL		1 / Muchalas	٧.		Res	- 000	)	(le	igu	ot 1	4 2005
	, 70		30. Name and address of person who co  Musicology  31. Date filed (Month, Day, Year)	mpleted cause of death (Ite  The Tithes Hopk  32. Registrar's Sign	m 23a) (Type, F	rint)	N. Cubl	le Street,	Ro He	iare	nD.	2/287
	Sta Registr	-	AUG 1 6 2		K 4	hadis						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Nancy L. Buck August 16 2005 7:16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Kline Hospice House Mt. Airy If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2XF 74 Yrs 212 28 4585 Sept 16,1930 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Ellicott City Howard the 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code ō 8409 West Grove Road 21043 United States 238 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify by 3 ₩idowed 4 Divorced White 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home of Health and Mental Hyginitem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be George H. Brinkley Mabel H. Titter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole L. Vogel/Daughter 1104 Cobblestone Lane Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges 1
Department of H
Important: If ite
ony injury or otl
gnce. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Gard. 8-20-2005 Marriottsville, MD 21. Signature of Funeral Service Licensee M01044 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hodakin **Physician** mouth /Medical Due to (of as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed ig physicien and as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use/contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2X No Be 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) hospice 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura And title of certifie 38500 August 17, 2005 of death (ttem 23a) (Type, Print) nebis mo 21044 VICHOUS 32. Pigistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. 2 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August Sophia Irene Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown Washington County Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🔀 F 85 219-12-2083 05/13/1920 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County in then "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No MD Hagerstown Be Completed by Funeral Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US 21742 999 Security Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental Heant: If item 27 is marked ott jury or other treumatic even Steve (unk) Uzelac Mamie Ellen (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 999 Security Road, Hagerstown, MD 21742 Dennis L. Brown / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Rest Haven Cemetery 08/20/2005 Hagerstown, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner Physicien: The law requires that the death certificate be executed burial-transil 1928789 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funerel Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) IN MP 32. Pagistrar's Signature State Registrar